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This manual is intended as a source of information and assistance in the planning, organization, implementation, and evaluation of home care programs. There are ten major sections: (1) Introduction (review of the history of home care and definition of pertinent terms), (2) Program Planning, (3) Organizational Structure, (4) Coordination and Administration of Home Care Services, (5) Home Care Services (discussion of medical, nursing, social work, physical therapy, nutrition, occupational therapy, speech therapy, dental, home health aide, and homemaker services), (6) Additional Home Care Services (discussion of education, friendly visitor, meals, transportation, podiatry, psychology, recreational therapy, and work at-home program services), (7) Planning Patient Care, (8) Financing Coordinated Home Care, (9) Records, and (10) Evaluation. Appendixes include information regarding (1) training courses, (2) resources for training materials and consultation, (3) field trips, and (4) evaluation of training courses. (JK)

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Coordinated Home Care Training Manual

Department of Community Health Services
School of Public Health, The University of Michigan
Ann Arbor, Michigan
1966

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COORDINATED HOME CARE TRAINING MANUAL

The Home Care Training Center
Adult Health and Aging Program
Department of Community Health Services
School of Public Health, The University of Michigan
in cooperation with
The Visiting Nurse Association of Metropolitan Detroit

prepared under
Grant No. CH 24-4
United States Public Health Service

Ann Arbor, Michigan
1966

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FOREWORD

This manual has been prepared as a source of information and assistance for those concerned with the planning, organization, implementation, and evaluation of home care programs.

As our population expands and the demand for comprehensive medical care continues to rise, home health services become increasingly important as a major component in the delivery of quality care. But too few people have access to home care today. The United States Public Health Service has for many years supported and encouraged the development of this important resource; it is essential to a comprehensive health care system.

Coordinated home care, with its advantages of patient assessment, continuity of patient care, and comprehensive services, remains the long-standing goal for most communities. Recent events resulting from the new health legislation have helped to broaden the definition of home care. The public is becoming aware of simpler approaches, and now minimally identifies "home health agencies" as sources of nursing care and one or more other health services in the home. But the certification of an agency to provide reimbursable services under Medicare is not an end point. It is the foundation for further growth and development with the eventual goal of the coordinated home care program.

From a practical standpoint, if we are to approach anything like national coverage for all those who should receive home care, there is need for immediate expansion of the type of care provided by home health agencies. In the long run, however, communities need to work toward coordinated home care programs. This manual is directed toward both goals, the immediate and the long-term.

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PREFACE

Every person, regardless of age, sex, or economic condition, should have access to comprehensive home health services whenever he has a need for this type of health care. Until a few years ago, only a limited number of patients, essentially the indigent, in a few metropolitan cities had access to home health services. Visiting nurse associations and a few health departments offered bedside nursing care or multiple services including nursing, physical therapy, and homemaker services.

The Visiting Nurse Association of Metropolitan Detroit, under the able direction of Emilie Sargent, pioneered in the development of a comprehensive home health program. Many citizens of Detroit, agency representatives, the McGregor Health Foundation, and the Detroit United Community Services worked together to demonstrate the feasibility of offering coordinated home care to patients of private physicians. As consultants to the Detroit Visiting Nurse Association Program, we became vitally interested in the evolution of the demonstration project into a full service program. The present program includes most of the large general hospitals of metropolitan Detroit, payment by third party payers, the extension of the services to larger numbers of patients of private physicians, and the inclusion of services from cooperating community agencies.

The School of Public Health began its activities in adult health and aging in 1953. As resources became available, full-time faculty were appointed to staff the Adult Health and Aging Program, and master of public health students were able to major in this area beginning in 1961. The importance of the home and the team care concept in health services was stressed from the inception of this program.

In response to a need to train agency personnel, a program for a series of short courses on coordinated home care was developed with the Detroit Visiting

Nurse Association in 1962 with the support of Dr. Claire F. Ryder, a friend and associate of long standing. Financial support was obtained through a Community Health Services Grant, Bureau of State Services, United States Public Health Service, with the Detroit Visiting Nurse Association as a joint sponsor of the training program, and the first course was offered by the Home Care Training Center in 1963. A total of 12 courses with 535 participants have been held between October, 1963, and March, 1966. Miss Sargent, now Director Emeritus of the Detroit Visiting Nurse Association, Miss Sylvia Peabody, the Executive Director, and their staff members advised, stimulated, contributed to, and otherwise assisted in the conduct of the courses.

While plans were being made for the training center, it was decided to prepare a training manual on coordinated home care. This decision was based upon recognition that this and other training centers could not meet all of the training needs for the rapidly expanding area of home care services.

Mrs. Virginia Williams, first Coordinator of the Center, began the outline of this manual and started a collection of references on coordinated home care. Under her able and dedicated leadership, the center developed a sound program of training. While developing plans for a short course in northern Michigan, she was killed tragically in an automobile accident on February 11, 1965. In July, 1965, Miss Cynthia Stewart was appointed Coordinator of the Center, and intensive work on the manual was begun in the winter of 1966.

The Detroit Visiting Nurse Association personnel and many of the faculty members of the short courses made substantial contributions to this manual, and materials developed by other home care training centers were used. This manual is, then, a distillation of the contributions of many persons, including those who have participated in the center's courses over the past three years.

At this time of burgeoning demand for more comprehensive health services, this manual can serve two primary purposes: (1) to assist in the training of new or inexperienced staff members in the rapidly developing home health service programs, and (2) to help home health service personnel plan, operate, and evaluate their program to assure effective and efficient services.

The challenge of providing coordinated home care in a dynamic and changing society must be taken up in all communities throughout the fifty states. While basic principles and methodology may be the same, infinite variety and flexibility must be built into each plan to adapt the program to the community and its changing needs.

Acknowledgements

Major credit for this manual is given to Cynthia Stewart, Assistant Professor of Public Health Nursing and Coordinator of the Home Care Training Center. We are indebted to Anthony Lenzer, Lecturer in Adult Health and Aging, School of Public Health, The University of Michigan, and to Sylvia Peabody, Executive Director, and Miriam Nikkila, Home Care Supervisor, of the Visiting Nurse Association of Metropolitan Detroit, for their assistance with the development of the manual. We are most grateful to all the persons who reviewed and contributed to the material presented in the various units. We thank Solomon Axelrod, M.D., Ella McNeil, Edith Oakes, and Claire Ryder, M.D., for their review of the final manuscript. We also thank Marie Caister and Jane Krystynak for their secretarial support and Nancy Mills for her editorial services.

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UNIT I

INTRODUCTION

What Is Home Care?

The meaning of the term "home care" seems to depend upon who is speaking. The term may convey a spectrum of services, organized or disorganized, ranging from family care of an ill member to a complex array of skilled professionals providing services in the home. The Social Security Amendments of 1965, under Title XVIII (Medicare), use the term "home health services."

Home Health Services include a variety of services provided in the home, but the term does not refer to the organization of such services. Only selected home health services are eligible for reimbursement under Medicare.

Organized Home Care was defined in 1955 as "those organized programs having centralized responsibility for the administration and coordination of services to patients and for providing at least the minimum of medical, nursing, and social services, essential drugs, and supplies."[1]

Coordinated Home Care evolved as a more definitive description of organized home care programs. The accepted definition is: A coordinated home care program is one that is centrally administered, and that through coordinated planning, evaluation, and follow-up procedures provides for physician-directed medical, nursing, social, and related services to selected patients at home. Home care is often used in this context.

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[1] A Study of Selected Home Care Programs: A Joint Project of the Public Health Service and the Commission on Chronic Illness, (Public Health Monograph No. 35), Washington, D.C.: U.S. Government Printing Office, 1955, p. 3.

Home care is one aspect in the continuum of patient care appropriate for selected patients at certain points in their disease process. Home care is not a substitute for hospital, extended care facility, or nursing home care, but it complements these. Alternatives for care must be evaluated in relation to the needs of the patient and the availability of services. When the needs of the institution are the sole motivation for planning alternatives for care, home care may become a "dumping ground" with referrals inappropriate to the program's ability to meet the patient's needs.

Levels of care of the sick at home are:

1. Patient, Family, and Physician. The physician works directly with the patient and family in providing the necessary care.
2. Patient, Family, Physician, and an Additional Service. Most commonly the additional service is nursing, but it may be social service, physical therapy, or homemaker service. This type of program is often referred to as a "single service program."
3. Multiple Service Program. Care is provided by a variety of professionals to assist the patient, family, and physician. These services may be available through one agency or several agencies.
4. Coordinated Home Care. Care is provided by a program that is centrally administered and that, through coordinated planning, evaluation, and follow-up procedures, provides for physician-directed medical, nursing, social, and related services to selected patients at home.

The Development of Home Care in the United States

The first home care program was established in 1796 in Boston to provide care for the indigent and medically indigent.

The growth of programs was spotty and very slow until 1947 when the hospital administered program was established at Montefiore Hospital in New York City. This marked a renewed interest in the concept of home care. Since 1955 more emphasis has been placed on administrative settings outside the hospital, and programs have developed in health departments and visiting nurse services.

Factors that gave impetus to the development of programs are:

1. The shift from acute to chronic illnesses as major health problems as a result of:
    a. Scientific and medical advancements
    b. Increase in life span
    c. Population increase with an increase in the older age groups
2. The sharply rising costs of hospital care due to:
    a. More complex services and facilities resulting from expanding knowledge
    b. Evolving role of the hospital as a community health center requiring that more services be available
    c. Increase in salaries and operating costs
    d. Increased costs of equipment and construction
3. Collective methods of financing health services through insurance and prepayment plans creating more demand for health services resulting in:
    a. Greater utilization of hospital beds
    b. Demand for comprehensive high quality services
4. The limited financial resources of the aged, their limited eligibility for health insurance, and their greater need for health services

Programs thus emerged from:

1. A hospital's need to improve the utilization of existing beds and reduce the need for more beds
2. Medical education's need to train physicians in the extramural setting
3. A desire to reduce public welfare costs for individuals in institutions
4. An identified community need to provide continuity of patient care and to furnish comprehensive care to patients in their own homes

Factors that are currently influencing program development and will continue to do so are:

1. Continued rise in hospital costs
2. Population expansion, with the older population increasing in number and age
3. Medical and scientific advancements in the prevention, treatment, and alteration of disease
4. Social Security Amendments of 1965 and other federal legislation
5. Expansion of third party coverage against the costs of medical care

Home care is important for:

1. Prevention of hospitalization or more appropriate planning for rehospitalization or institutionalization
2. Psychological benefits connected with the home:
    a. Familiar environment
    b. Maintenance of dignity
    c. Supportive family relationships
    d. Rehabilitation carried out in the setting appropriate to the goals
3. Enabling earlier hospital discharge for the patient who no longer requires the intensive, highly complex services of the hospital but requires continued coordinated professional services

A coordinated home care program is based on the assumptions that:

1. The home is an appropriate place to provide selected patient care services
2. The family itself, not the physician or agency, may be the most important resource for care in the home
3. The patient is an active and important figure in the situation, not just a passive recipient of care
4. Home care is a phase of patient care in its own right, and is not a substitute for hospitalization

The program incorporates the principles of:

1. A centrally administered program

2. Physician-directed services
3. Services available to all age groups and to all persons regardless of economic status
4. Evaluation of the patient's status before admission and periodically thereafter
5. Evaluation of the suitability of the home and the ability of household members to participate in the care of the patient
6. Rapid transfer of the patient from the home to another kind of care facility if his condition should require it
7. A referral system for transmitting pertinent information to and from the home care program when services are needed
8. Involvement of other agencies, if needed, to furnish services in accordance with contracts or agreements
9. The administering agency acting to coordinate those facilities or services furnished in the program by other agencies
10. Sound fiscal support, including ability and freedom to pay for contracted services, collect fees, and receive funds from other agencies
11. A qualified staff working under professional supervision
12. Adequate and appropriate clinical records and data

Planning A Home Care Program

The decision to develop a program should be based on:

1. Community needs
2. Community resources
3. Available leadership

It is important to differentiate between a coordinated home care program and a home health service program. Coordinated home care identifies a program that offers a range of services within an administrative structure providing centralized coordination and planning. A home health service program, which may or may not have this centralized mechanism for coordination, refers to the kinds of services rather than the organizational structure. As a home health agency becomes eligible for Medicare certification, development of a coordinated home care program would be a logical next step.

The basic coordinated home care services are:

1. Physician services
2. Nursing
3. Social service

Other services which may be provided are:

1. Physical therapy
2. Occupational therapy
3. Nutrition services
4. Speech therapy
5. Dental services
6. Home health aide services
7. Vocational rehabilitation
8. Drugs, supplies, equipment
9. Transportation
10. Oxygen and blood
11. Home delivered meals
12. Laboratory and X-ray services

Responsibilities of the administering agency include:

1. Coordination of services under qualified professional direction
2. Provision and supervision of qualified staff
3. Sound administration-management practices
4. Responsible fiscal management
5. Maintenance of clinical and statistical records
6. Evaluation of the program
7. Staff education

Approaches to program development are:

1. Initiation of a comprehensive program where resources are readily available

2. Addition of other services, such as social work, physical therapy, and the coordinating mechanism for these services, once the bedside nursing service is established

Suggested Readings

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(Public Health Service Publication No. 1062.) Washington, D. C.: U. S. Government Printing Office, 1963. A resurvey, in press (Fall, 1966), will replace this publication.

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Chapter 1: "Elements of Progressive Patient Care," Jack C. Holderman.

21: "Characteristics of Long-Term Patients," Dean E. Krueger and Dean W. Roberts.

24: "Essentials and Objectives of After-Care Programs," David Littauer.

UNIT II

PROGRAM PLANNING

Introduction

Development of a home care program does not necessarily mean development of a new program. It can refer to geographic extension of service by an established program, adding services to an established program, or revamping an old program, as well as to initiation of a new program. The term community refers to the area to be served, which may cut across political or traditional service boundaries.

To plan a home care program:

1. Identify the need for services
2. Determine the desirability to meet the need
3. Consider alternative ways to meet the need
4. Select a method to meet a reasonable part of the need

Community Planning

Program planning for home care should be preceded by community planning for health services. The kinds of health care problems existing in the community determine what programs are needed and what priority should be given to these programs.

Steps in community planning for health services are:[1]

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[1] Based on Getting, Vlado A., "Planning, Implementation, and Evaluation of Community Health Services," *Journal of the Canadian Public Health Association*, Vol. 55, December, 1964, pp. 512-521.

1. Organize a responsible community planning group
2. Gather facts and opinions, and determine interrelationships of agencies and individuals
3. Determine needs and wants of the participating groups, the public, public officials, and community leaders
4. Determine unmet needs or the lack of adequate facilities pointed out by the inventory of the total needs of the community
5. Define in measurable and reasonable terms the community's specific objectives for solving unmet needs or future needs as the community sees them

Community planning may indicate that a coordinated home care program is necessary and desirable. This could mean that:

1. An existing program should expand the area served or the services provided
2. An existing program providing health services in the home should make major changes in either administration or methods
3. A new program should be established

A planning group for program development should be formed to assist in establishing a new program or making the necessary changes in an existing program. This group must carefully determine the degree to which needs are met, as well as the degree to which the program should plan to meet the need. To fulfill its responsibilities, the planning committee must have leadership, facts, and the confidence of the appropriate organizations, institutions, and community leadership.

Program Planning

Steps in program planning are:

1. Identify the problem and determine the need: The problem may be the organization of services, for example:
    a. Complete lack of home care services

   b. Limitation of home care services either geographically or in types available
   c. Limitation in effectiveness, efficiency, or the number of people served by a home care program because of the methods of organization, administration, or financing

The extent of need for services may not be known. However, estimates, which may justify initiating a program, may be determined from:

   a. Data already available in the community concerning known patients who might profit from services
   b. Formulas developed by the Public Health Service based on incidence of chronic disease and disability in the general population that can be applied to the particular community

Estimates may be valid for only that given point in time when the information is obtained. The initial program may be influenced by:

   a. Illness pattern of the community
   b. Extent to which the program is known, accepted, and used

Programs, therefore, should be constructed in anticipation of expansion or modification as experience indicates.

2. Determine the availability of resources including:
   a. Qualified staff
   b. Financial support
   c. An administering agency
   d. Operational locations, i.e., office facilities and branch offices
   e. Equipment and supplies
   f. Cooperation of physicians, hospitals, and other community agencies
3. Determine services to be offered, both professional and supportive.
4. Determine deterrents to be overcome in program development:
   a. Lack of or limited resources
   b. Unfavorable attitudes in the community, lay or professional, concerning the acceptability of certain services or the structuring of service

   c. Strained relationships between the various groups and agencies to be involved
   d. Staff attitudes, work loads, and acceptance or rejection of new program responsibilities
   e. Effect of the proposed program on existing programs within an agency

5. State objectives:
   Ideally objectives should be stated as desired outcomes within a specified time for a specified population, for example, "By a given date all patients in all hospitals will be evaluated for continuing care needs in relation to referral for home care." However, until a program has experience, objectives stated as outcomes may not be possible. The plan of a newly evolving program may be stated as: "To provide home care to X number of patients in Y area during Z year."
6. Determine specific activities necessary to achieve the objectives, establishing the program plan
7. Determine an evaluation process to periodically measure the success of the program

Program Advisory Group or Committee

This group advises the organization responsible for the program's development and administration. Its functions may vary with the legal responsibilities of the agency's or organization's governing body.

The functions of an advisory group may include:

1. Periodic review of the home care program's objectives
2. Periodic review of the criteria for patient eligibility
3. Formulation or approval of written policies and procedures and their periodic review
4. Stimulation of the program's use by attending physicians on behalf of their private patients

5. Informing the public of available resources and facilities made possible through home care so as to stimulate their seeking such services on behalf of home-bound patients
6. Development of methods for coordination and joint planning whenever services are rendered by several groups or agencies in the community
7. Seeking financial support for such portion of the program that is not self-sustaining
8. Encouraging the inclusion of home care benefits by third party payers
9. Continuing to carefully observe the progress of the program, enabling it to be as flexible as possible to meet changing needs and knowledge
10. Reporting to the community at large and to financial sponsors conveying the value of the program and identifying its needs and limitations
11. Relaying to the home care team and administering agency the community's acceptance, understanding of the program, and suggestions for improvement
12. Providing technical and professional advice in areas such as patient care services, financing, administrative management, and public relations

Composition of the advisory committee should be determined by the functions assigned to the group. Those agencies who wish to participate in the Medicare program must incorporate Condition IV of Conditions of Participation for Home Health Agencies in their selection of an advisory group.

Principles of working with advisory groups include:

1. An informed group is more likely to support the program than an uninformed group
2. The group should be involved in the problem-solving process
3. People resist being formed into a group to "rubber stamp" somebody else's plan
4. There must be willingness to accept and use the skills and knowledge of the group

The Medical Community

The medical community should be actively involved in the planning of a home care program, and the first approaches should be made to the local medical society and the osteopathic society, if one exists. Their endorsement will help the individual physician make his own decision about participation. The home care program may establish working relationships with faculty of medical schools, hospital medical staffs, and closed panel medical groups.

The administering agency must clearly state its role in order to get the full cooperation of the practicing physician.

A medical advisory committee or professional advisory committee should have several physician members, either appointed or endorsed by the local medical society.

Suggested Readings

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UNIT III

ORGANIZATIONAL STRUCTURE

Introduction

Determining the organizational structure of a home care program is a part of program planning. In some communities planning proceeds very smoothly until it is necessary to decide on the administering agency.

The terms "hospital-based" and "community-based" are misleading. It is more appropriate to identify the administering agency as such, e.g., hospital administered or health department administered. The home care office may be physically located in a hospital, although the program is administered by a visiting nurse service, health department, or other agency, or a hospital administered program may purchase some services from other community agencies.

Regardless of who administers the program, physicians, hospitals, and other community health agencies must be actively involved.

In determining the administering agency consider:

1. Leadership available within the agency
2. Agency willingness to administer the program
3. Confidence of the medical and other professional groups in the agency

Sometimes a medical school or research program has interest in establishing a home care program for special categories of patients, but this does not negate the need for a community-wide program. Efforts should be made to build into one program, if possible, the meeting of community needs as well as special purpose needs.

The Administering Agency

The agency selected to administer the program should have:[1]

1. Qualified professional direction, such as a physician, nurse, social worker, or hospital administrator
2. Qualified staff
3. Administrative qualities, such as:
    a. Effective personnel policies and practices
    b. Necessary space and equipment
    c. Accounting system and fiscal management practices
4. Legal right or permission to deliver home care services and to collect and disburse monies for these services
5. Methods for collection and analysis of program information
6. Responsibility for program evaluation and reports to the community
7. Ability and willingness to set high standards for itself and for the delivery of patient care services
8. Firm community commitments
9. Protection against the development of problems of vested interest in its operations
10. Flexibility in its practices
11. Experience in providing services in the home, if possible
12. An advisory body broadly representative of the community, professions, and agencies

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[1] Based on the paper "Coordinated Home Care in New York State: The Rationale and Recent Developments" presented by George M. Warner, M.D., at the Second Institute on Coordinated Home Care, Montefiore Hospital, Bronx, New York, April, 1963 (unpublished).

Types of Administering Agencies

The advantages of one type of agency as administrator over another will depend, in great part, on the community involved. However, experience of other programs have identified strengths and potential problems that should be considered in planning the administrative setting. The potential problems are not found in all programs and can be overcome through careful planning.

Hospital Administered Program

The advantages are:

1. Accessibility to physicians
2. A developed system for some quality control of medical care
3. Easy access to medical records
4. Readily available hospital services
5. Short notice readmission to the hospital without formidable admission procedures

Potential problems are:

1. Hospital jurisdiction in a community-wide program when there are several hospitals in the community
2. Provision of home care to all in the community who can benefit from the service including nonhospitalized patients
3. Full integration of the program with all practicing physicians in the community
4. Duplication of existing services for the same population
5. Absence of, or weak working relationships with, other health and welfare agencies
6. Hospital bed utilization rate rather than patient care needs affecting referrals to home care
7. The nature of the commitment of the hospital administrator and board to the role of the hospital in extramural services

Health Department or Visiting Nurse Service Administered Program

The advantages are:

1. Experience in provision of services to the sick at home
2. Ability to provide community-wide services
3. Legal and administrative framework for providing home care services
4. Knowledge of community resources and their use for patient care services
5. Access to and experience with a variety of financial resources for home services, i.e., tax monies, community drive funds, and patient fees

Potential problems are:

1. Lack of close collaboration with the hospital or hospitals
2. Limited or no access to medical records
3. Limited personal physicians' participation in establishing a long-term program of care and in periodic conferences on patient progress
4. No hospital bed formally available
5. Dependence in large part upon the effectiveness and orientation of the hospital liaison persons for volume of referrals
6. Attitude of the general public that services are for "charity cases"
7. Insurance laws in some states prohibiting reimbursement by insurance and prepayment plans for services not provided by a hospital
8. Visiting Nurse Service: Restrictions on expansion of service area by the United Fund or Community Chest
9. Health Department: Laws in some states prohibiting collection of fees, dependence on local tax base for agency support and limitation to political boundaries restricting program development or expansion

Once the administering agency is selected, program placement within the organization will depend on that agency's structure. Home care may be a separate program or department, or a unit within an existing department, section, or program area.

Home Care for Rural Areas

Problems in provision of home care services are:

1. Lack of professional personnel
2. Lack of community organization experience
3. Scarce facilities and institutions
4. Sparse population with long distances between patients increasing the costs and manpower time per case
5. High proportion of aged, chronically ill, and disabled people
6. Economic infeasibility of employing specialized staff, such as social workers, for small caseloads

A coordinated home care program may be unrealistic and inappropriate for each small community or county in the light of these problems. A regional approach may provide a more realistic base, in terms of population and resources, for such a program.

Regional Organization

Regional organization, appropriate not only for rural areas, but also for urban and metropolitan areas, involves:

1. Encompassing several counties or municipalities
2. Having an independent, voluntary home care agency or regional health department as administering agency
3. Gaining support of a greater number of people and several governmental units
4. Providing the same services to the entire region
5. Having professional direction and supervision
6. Using and coordinating the existing services and facilities in the region
7. Providing for:
    a. A main office in a centrally located, large population center to

house the administrative and consultant staff

b. District offices in the county seat or a central community in each county or similar jurisdiction, located in a court house, hospital, medical arts building, or other service building, to house supervisory personnel, consultants, if available, and field staff

c. Local offices in the small communities, if necessary, located in a town hall, public meeting place, or other accessible building, to provide ready access to a telephone and a communication point for field staff

Suggested Readings

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Holmes, Edward M., *et al.* " The Richmond Home Medical Care Program," Medical Care in Transition: Reprints from the American Journal of Public Health, Volume I. (Public Health Service Publication No. 1128.) Washington, D. C.: U.S. Government Printing Office, 1964.

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28: "Home Care: Summary of a Comprehensive Study," David Littauer, I. Jerome Flance, and Albert F. Wessen.

29: "A Home Care Program for a Small Community," John R. Griffith.

30: "How Home Care Works in a City of 48,000," Henry E. Markley and Jacob Brauntuch.

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UNIT IV

COORDINATION AND ADMINISTRATION OF HOME CARE SERVICES

Introduction

As mentioned earlier, the distinguishing feature of a coordinated home care program is the administrative provision for coordinating services. Effective coordination and administration of these services requires an identifiable administrative team.

The Administrative Team or Coordinating Unit

The team should be composed of:

1. A physician serving as Medical Director or Medical Advisor to the program. A medical director usually carries administrative responsibilities, whereas a medical advisor most often serves as a consultant.
2. A public health nurse
3. A social worker
4. Sufficient secretarial support
5. An administrative assistant, if one is employed by the program

The physician, nurse, social worker or professional administrator may be designated as the administrator or coordinator of the program with responsibility for the day-to-day operation. In some programs the physician and social worker may serve as consultants without direct administrative or service commitments to the program and are available to the program on a part-time or hourly basis.

Functions of the administrative team or coordinating unit are to:

1. Administer the program and supervise staff as appropriate

2. Admit and evaluate patients referred to the program
3. Plan, review, and modify individual patient service schedules
4. Implement, coordinate, and direct patient services provided by the various professions
5. Determine discharges
6. Consult with the various professionals providing direct patient services
7. Participate in ongoing educational programs for the home care staff, agency staff, or professional groups

Medical Director or Advisor

A home care program is a medical care program making a medical director or advisor an essential member of the administrative team. In this role on the home care team he does not treat patients.

The physician may serve on a part-time or full-time basis, depending on the size of the program and his responsibilities in it. If the program employs a medical staff or provides training for medical students, interns, or residents, a full-time medical director may be necessary to insure patient assignment and supervision of medical care.

Functions of the physician member may include:[1]

1. Providing overall direction of the program
2. Acting as liaison between the home care program and the medical community
3. Evaluating the suitability of patients for home care in consultation with the attending physicians

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[1] Based on the paper "The Role of the Medical Advisor in the Home Care Team" presented by Sidney E. Chapin, M.D., at the Conference on Coordinated Home Care, School of Public Health, The University of Michigan, April 13-17, 1964 (mimeographed).

4. Contacting the attending physician in matters other than routine orders when necessary
5. Reviewing the medical records of patients in the program upon admission and discharge with regular interval reviews of patient progress, if possible
6. Assuring continuity of medical care for patients admitted to the program
7. Evaluating the quality of medical care that the patients in the program receive
8. Serving as medical consultant to other members of the home care team and to all those who are in contact with the individual patient
9. Sharing responsibility for educational programs for all of the professional people engaged in the program
10. Serving as advisor to the Board of the administering agency
11. Serving as a member of the advisory committee or medical advisory committee to the home care program

Preferably the physician member should be:

1. In active practice, e.g., as a health officer, medical educator, salaried physician or private practitioner
2. From the community in which the program is operating
3. A member in good standing of the local medical society
4. Able to discuss patient care frankly with attending physicians and have rapport with his fellow practitioners

Program Administrator or Coordinator

The administrator may be a physician, social worker, or a professional registered nurse, preferably a public health nurse. Or the program may be administered by a professional administrator with the assistance of the coordinating team to make the professional decisions regarding the provision of health services.

Functions of the Program Administrator or Coordinator are:[1]

1. Identifying potential patients for admission to home care
2. Ensuring proper evaluations of the patient's medical, nursing, and social needs according to the approved criteria and evaluation procedure
3. Coordinating services necessary to carry out the attending physician's orders for his patient's care
4. Ensuring that referral forms and service reports are properly and promptly completed and transmitted to the appropriate person or agency
5. Maintaining clinical, administrative, and statistical records
6. Establishing procedures for efficient delivery of services
7. Assisting in the discharge of patients from the program
8. Serving as liaison between the program and other community agencies
9. Sharing responsibility for community and staff education
10. Furnishing the advisory groups and agency director with necessary information and reports concerning the program's operation, services provided, and program evaluation
11. Sharing responsibility for the fiscal aspects of the program

Hospital Liaison or Coordinator[2]

In many programs the need has developed to identify potential home care patients while they are still in the hospital or extended care facility so that they may be referred to the program. These activities may be carried out by a person of any health discipline but are most often performed by a professional nurse. Regardless of the administering agency, the hospital, with the help of a home care program coordinator, has the major responsibility for identification and referral of potential home care patients.

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[1] Some of these functions may be delegated to other members of the home care staff.

[2] This would also apply to extended care facilities.

The home care program may employ a hospital coordinator either on a part-time or full-time basis. Experience has shown that a full-time coordinator is needed in a large hospital (over 400 beds). This person, preferably a nurse, should be a hospital employee, and the program should assign a liaison nurse to work with the coordinator on a part-time basis. In small hospitals participating in the program someone, preferably a nurse, should be designated by the hospital to work part-time with the program coordinator.

Functions of the liaison person or coordinator are to:

1. Orient hospital personnel to home care procedures, with assistance from other home care team members and hospital administration
2. Maintain close communication between the hospital and the home care program
3. Discuss potential home care patients with physicians and head nurses, and, after physician approval, discuss home care with the patients and their families
4. Attend medical staff rounds whenever possible
5. Assist hospital personnel in predischarge planning
6. Initiate or organize predischarge planning conferences as needed
7. Discuss home care procedures with the physicians, nurses, patients, and families and assist with the proper completion of necessary forms
8. Arrange for predischarge home visits, which may be made by any member of the home care team, to evaluate and prepare the home and family
9. Arrange, for appropriate team members, observations and teaching of special procedures needed by the patient after his discharge

Hospital Administrator

Although the hospital administrator is not a member of the home care administrative or coordinating team, his involvement and interest are vital.

The hospital administrator contributes to the home care program by:

1. Providing a hospital employed coordinator to identify potential home care patients
2. Providing clerical support in completion of necessary forms
3. Making available the departments involved in patient care and services and providing mechanisms for intra-hospital communication
4. Developing administrative procedures so the home care team may readily obtain necessary equipment, supplies and drugs
5. Providing access to medical records and developing a system to transmit necessary medical information to the home care program
6. Supporting the concept of home care by providing time for orientation of and ongoing education for hospital personnel
7. Assisting in the development of procedures for rehospitalization on short notice of home care patients

Suggested Readings

Conditions of Participation for Home Health Agencies: Health Insurance for the Aged. (U.S. Department of Health, Education, and Welfare, Social Security Administration, HIM-2.) Washington, D. C.: U.S. Government Printing Office, 1966.

Littauer, D., Flance, I. J., and Wessen, A. F. Home Care. (Hospital Monograph Series No. 9.) Chicago: American Hospital Association, 1961.

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Chapter 26: "Securing Early Referrals to Home Care," Miriam Nikkila.

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UNIT V

HOME CARE SERVICES

Introduction

This unit is divided into sections, each dealing with a home care service, with emphasis on the role of the professional and subprofessional staff providing service in a home care program. The amount of time and detail given for each service within the training course will depend upon the course objectives and the composition of the group of trainees. During the training course a member of a given profession should be invited to attend the class either to discuss his profession's particular contribution to home care or to be available for consultation.

The sections of this unit cite several specific functions of each team member as they apply to home care. However, all of the members of the home care team are responsible for:

1. Actively participating in the establishment of overall patient care goals and in the evaluation of progress towards these goals
2. Recording and reporting to the attending physician and other team members, as appropriate, the care given, observations of symptoms, reactions to treatment, and other pertinent information
3. Interrelating with others providing services to the patient and communicating with team members
4. Interpreting his own profession's contribution to patient care in the multidisciplinary team setting

Qualifications for home care personnel are not included in this manual. This information for each profession can be obtained from:

The American Dietetic Association
The American Nurses Association

The American Occupational Therapy Association
The American Physical Therapy Association
The American Public Health Association
The American Speech and Hearing Association
The National Association of Social Workers

The Conditions of Participation for Home Health Agencies for Medicare also cite qualifications and functions of personnel.

Supervision of staff members in their professional practice should come from a qualified member of their own profession. Home care programs must include consideration of sources for staff supervision and make necessary arrangements for this. The experience, maturity, and level of professional competence of the staff members will influence the amount of supervision required.

Social Work, Physical Therapy, Occupational Therapy, Speech Therapy, and Nutrition may be provided by a home care program on a full- or part-time basis. The professional may serve in a primarily consultative role, render direct service to patients, or both.

The use of a service in a program depends upon:

1. Direct services that the program proposes and can afford to provide for its patients
2. Services already existing in the community and their availability to the program
3. Availability of qualified personnel

Personnel may be added to the home care team through employment, by the home care program or by the administering agency with full- or part-time assignment to the home care program, or through contracts or written agreements with other employing agencies, institutions, or private practitioners.

The scarcity of all professional personnel has been a problem to existing programs and will be a major concern to all future programs. Because of this and other limitations, a program will seldom be able to offer all of the services presented in this manual, but a comprehensive program should be the goal for all agencies.

Section 1

Medical Service

The role of the medical director or advisor was discussed in Unit IV. This section primarily deals with the role of the attending physician in a home care program.

All patients who are admitted to the home care program must be under the care of a physician and remain so. This physician must be an active member of the home care service team in the provision of services to his patient.

The home care team must inform the physician, on a continuing basis, of the services provided to his patient and of the patient's response to these services. Likewise, the physician is responsible for informing the home care team, at regular intervals, of his patient's medical status and changing needs.

The attending physician in home care is responsible for:[1]

1. Awareness of home care as one of the phases of total care for his patient and desire to have his patient served by this kind of program
2. Selection and referral of patients to the home care program
3. Supervision of the patient's treatment and care
    a. Seeing the patient, either at home or in the office, as required by the patient's condition

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[1] Based on the paper "The Professional Community in Home Care" presented by Sidney E. Chapin, M.D., at the Conference on Home Care, School of Public Health, The University of Michigan, November 29-December 3, 1965 (mimeographed).

    b. Writing specific orders for medications, treatment, and care
    c. Providing the necessary medical services he would ordinarily provide in any other setting

4. Provision of pertinent information regarding the patient's diagnosis and course of illness to the home care program
    a. Completing hospital discharge summaries
    b. Maintaining medical records and furnishing periodic medical reports to the home care program
5. Standards of medical care furnished to his patient
6. Consultation with home care team members providing service to his patient
7. Cooperation with other physicians also involved in the care of his patient, e.g., surgeon or internist
8. Determination, along with the home care team, of discharge of the patient from home care

In turn the home care team is responsible for:

1. Intensive educational program to interpret to the physician the values of a home care program
2. Preserving the doctor-patient relationship
3. Ongoing orientation of the physician to use home care
4. Assistance with referral mechanics to obtain the necessary information from the physician without a multiplicity of forms or time consuming procedures
5. Developing and maintaining efficient and acceptable communication methods
6. Ensuring flexibility in arranging the home care conferences at the convenience of the physician

Suggested Readings

Conditions of Participation for Home Health Agencies: Health Insurance for the Aged. (U.S. Department of Health, Education, and Welfare, Social Security Administration, HIM-2.) Washington, D. C.: U.S. Government Printing Office, 1966.[1]

Doyle, J. C. "The Role of the Private Physician in Coordinated Home Care," Journal of the American Medical Association, Vol. 185, September 7, 1963, p. 782.

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[1] This reference pertains to the sections on nursing, social work, physical therapy, speech therapy, occupational therapy and home health aides.

Section 2

Nursing Services

Nursing service that is available in the community is basic and essential to providing care of the sick at home. A program for nursing service must be developed if no such service exists in a community.

Community resources for nursing service for a home care program are:

1. Health Department
2. Visiting Nurse Association
3. Combination Agency (official and voluntary)
4. Hospital

Some programs have offered home nursing through the hospital (hospital employed public health nurses); however, this should be considered only when there is no community nursing service and no interest in developing such a service.

The home care program, as pointed out in the previous units, may develop from an established community nursing service, and Medicare will undoubtedly foster this. However, programs administered by hospitals, independent agencies, or health departments may contract for service from an established community nursing agency.

The nursing service within the home care program may be provided by a team of nursing personnel composed of a public health nurse, a registered nurse without public health preparation, and a licensed practical nurse or vocational nurse.

The responsibility for patient care rests with the public health nurse. However, all the nursing team members possess skills contributing to patient care. Specific functions of the team members should be clearly defined in the written personnel policies of the employing agency, since they may vary from one agency to another depending upon the situation. In some agencies the registered nurse without public health preparation may serve as the team captain. In this case it is strongly recommended that this nurse work under the direction of a qualified public health nurse.

In a coordinated home care program the public health nurse is most likely to:

1. Evaluate the patient's nursing care needs upon admission to the program
2. Evaluate the home and family members' abilities to meet the care needs of the patient
3. Provide her assessment of nursing needs and possible methods of accomplishment to the home care team
4. Establish a nursing care plan based upon the physicians orders and nursing needs
5. Evaluate and assign nursing and personal care activities to other nursing team members, home health aides, and family members
6. Teach and supervise other nursing team members, home health aides, and family members in carrying out nursing or personal care activities
7. Provide skilled nursing care to those patients whose conditions require professional nursing judgment
8. Evaluate nursing care rendered by herself and other nursing team members, including the home health aide, in relation to accepted standards of nursing practice and the team's goals for a given patient

The practical or vocational nurse, who works under the supervision of a registered nurse, is an important member of the nursing team in that she can carry out specified procedures thus allowing the professional nurse to function at her highest level. Because of the setting for home care, the practical nurse must be carefully selected. She will be working where professional personnel are not immediately available, and she must be able to record and report accurately her observations and contacts with patients and families.

Suggested Readings

Cohen, Hedwig. "Adapting Home Health Services to Medicare," Nursing Outlook, Vol. 14, June, 1966, p. 28.

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Functions and Qualifications in the Practice of Public Health Nursing. New York: Public Health Nurses Section, American Nurses' Association, 1964.

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Parker, Mary E. "Home Care Programs for New Yorkers," Nursing Outlook, Vol. 11, June, 1963, p. 412. Adams, Martha. "Staffing with a Difference" (Letter), Nursing Outlook, ibid., p. 481. These articles should be used together.

Wilson, Alberta. "Long-Term Nursing Care in Rural Minnesota," Nursing Outlook, Vol. 12, October, 1964, p. 69.

Section 3

Social Work Service

Social work service is one of the three basic services in a coordinated home care program.

Functions of the social worker include:

1. Evaluating the psycho-social situation of the patient being considered for home care:
    a. Family relationships
    b. Meaning of illness to the patient and family
    c. Cultural attitudes in relation to illness
    d. Meaning of the home to the patient
    e. Ability of the patient and family to adjust to the patient at home
    f. Financial impact of illness upon the family
2. Interpreting to the team social factors in the patient's situation that may have bearing on his progress
3. Working with the patient, family, and physician on alternative planning using appropriate community resources, if the patient is not a suitable candidate for home care
4. Helping patients and families understand and accept the illness and anticipate its accompanying adjustments
5. Coordinating resources to alleviate the financial impact of illness, and assisting the patient and family in planning for payment of medical care
6. Determining the need for continued social work service, and drawing upon other community agencies that can further assist the patient and family; or serving as liaison with community social agencies currently active with the patient and family
7. Coordinating the social service in the hospital, if such service is available, with the home care program
8. Assisting with planning of discharge from the home care program

9. Selecting activities for and supervising the case aide or social work assistant[1]
10. Stimulating and participating in planning and development of appropriate community programs

The social work consultant may carry out any of the functions already cited; however, as a consultant he is most likely to:

1. Suggest to team members what information is needed and how it can be obtained in order to better understand the patient and family, and interpret this information
2. Apply social work knowledge to the particular patient situation of concern to the team, and provide assistance regarding what techniques to use, when to try, when to refer, when to withdraw, and what the alternatives are
3. Assist team members in selection of proper community resources, help determine what information may be most meaningful to the other agencies, and suggest ways in which the team members can help the family use such resources
4. Consult with other agencies for appropriate information, participate in interagency case conferences, and serve as liaison between social work agencies, social service departments, and the home care program
5. Participate in staff and community educational programs

If a consultant is used, it is important that consultation be provided to the home care program on a regularly scheduled basis.

Social workers are available through other community agencies, such as a hospital, social agency, welfare agency or a private practitioner, or social work consultation service is available through the state health or welfare department. An alternative is to recruit an experienced, qualified worker who has retired from active practice or one who would work part-time and for whom an orientation to health agency practice would be planned.

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[1] Case aides or social work assistants have been used in social service agencies and hospital social service departments. Their functions and responsibilities within a home care program must be determined by a qualified social worker.

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Selected Papers from an Institute: Coordinated Home Care. Pittsburgh: Home Care Department Training and Information Center, Montefiore Hospital Association of Western Pennsylvania, 1963.
Chapter 6: "Social Service Evaluation," Dorothy Taylor
7: "The Social Worker's Viewpoint of Home Care," Ruth L. Grossman.

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Chapter 6: "Social Work's Responsibility in the Provision of Comprehensive Medical Care in Long-Term Illness," Evelyn F. Cooper and Lillian R. Mark.
8: "NASW'S Concern with the Needs of Long-Term Patients," Doran Teague.

Ullman, Alice. "Social Work in a Home Care Program," *Journal of Chronic Disease*, Vol. 15, September, 1962, p. 925.

Physical therapists are available through:

1. Hospitals
2. Rehabilitation centers
3. Official agencies or governmental programs such as:
    a. State health or welfare departments
    b. Vocational Rehabilitation
    c. Crippled Children's Commission
4. Voluntary organizations such as:
    a. American Heart Association
    b. Arthritis and Rheumatism Foundation
    c. National Foundation
    d. Society for Crippled Children and Adults
5. Private therapists (district physical therapy associations may have a list of therapists who will work part-time or do private work)

Suggested Readings

Chabala, Lilian. "The Role of the Physical Therapist in Out-of-Hospital Programs," Journal of the American Physical Therapy Association, Vol. 43 July, 1963, p. 509.

Cook, Ruth. "Physical Therapy Personnel for Out-of-Hospital Services," Journal of the American Physical Therapy Association, Vol. 46, March, 1966, p. 239.

Holly, Lydia. "Physical Therapy in Home Care: Community Focused or Patient-Centered?" Journal of the American Physical Therapy Association, Vol. 44, October, 1964, p. 901.

Littauer, David, and Hickok, Robert. "The Role of the Physical Therapist in a Home Care Program," The Physical Therapy Review, Vol. 39, April, 1959, p. 220.

Section 4

Physical Therapy

In addition to those factors already cited, the use of a physical therapist in a home program is influenced by the number of patients requiring physical therapy services and the distances and time involved in providing direct service.

The functions of the physical therapist in a home care program include:

1. Assessing the patient's functional ability, strength, and mobility
2. Assessing the patient's physical environment and his performance in this environment
3. Establishing a rehabilitation program under medical orders within the limitations of the home environment and personnel resources
4. Teaching, supporting, and, when necessary, supervising nurses, home health aides, family members, and others who may be working with the patient, as well as the patients themselves
5. Periodically assessing the patient's status and recording and reporting the findings
6. Recommending and arranging for assistive devices and equipment that seem indicated for the patient's rehabilitation and are approved by the physician, and periodically inspecting the equipment and appliances

If the therapist is serving primarily as a consultant, he may carry out any of the activities already cited; however, he is most likely to:

1. Evaluate the patient and instruct other team members, usually the nurse, in performing appropriate activities in the rehabilitation plan
2. Obtain specific orders from the physician regarding physical therapy treatments
3. Evaluate the patient's progress and determine progression of the treatment plan if progression is ordered by the physician
4. Confer with team members and other consultants

Physical therapists are available through:

1. Hospitals
2. Rehabilitation centers
3. Official agencies or governmental programs such as:
    a. State health or welfare departments
    b. Vocational Rehabilitation
    c. Crippled Children's Commission
4. Voluntary organizations such as:
    a. American Heart Association
    b. Arthritis and Rheumatism Foundation
    c. National Foundation
    d. Society for Crippled Children and Adults
5. Private therapists (district physical therapy associations may have a list of therapists who will work part-time or do private work)

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Chabala, Lilian. "The Role of the Physical Therapist in Out-of-Hospital Programs," Journal of the American Physical Therapy Association, Vol. 43 July, 1963, p. 509.

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The Role of the Physical Therapist in Home Care and Nursing Home Programs. St. Louis: Training Center for Coordinated Home Care and Other Out-of-Hospital Health Services, Jewish Hospital of St. Louis, 1963.

Section 5

Nutrition

Nutrition service is an integral component of a home care program not only because of the therapeutic dietary needs of certain patients but also for the dynamic role of diet in rehabilitation, recovery, and maintenance of all patients. Many coordinated home care programs provide this service, with the nutritionist usually serving as a consultant rather than providing direct service.

Assuming that the nutritionist will serve primarily as a consultant, her functions may be primarily focused upon:

1. Identifying and interpreting to the team members realistic dietary goals for the patient based on assessment of the patient's food habits and practices
2. Adapting normal diets to the patients' needs and developing therapeutic diets according to medical prescription
3. Guiding team members in techniques of counseling on nutrition, and developing their knowledge of nutritional needs and methods of meeting these needs
4. Consulting with team members on nutritional needs of individual patients and families
5. Participating in staff educational programs both for professional personnel and non-professional personnel
6. Providing direct service when necessary
7. Acting as liaison between community nutrition services, hospitals, other institutional dietary departments, and the home care program

8. Participating with other public health nutritionists or dieticians, in the development of nutrition services for the community, e.g. home delivered meals

Consultation service of a nutritionist can be arranged through a hospital, extended care facility, health department, or other community or state health agency.

If the administering or home care agency serves other patients in addition to those admitted to the home care program and the total patient load is large, they may wish to employ a full-time nutritionist to serve in all of the agency's programs or units.

Suggested Readings

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Section 6

Occupational Therapy

In the absence of an occupational therapist, another member of the team may assume some of the occupational therapist's functions in the home care program. The functions of the therapist are:

1. Evaluating, along with other members of the team, the patient's level of functioning
2. Establishing, through medical referral, an occupational therapy treatment plan
3. Guiding the patient in activities of daily living, e.g., eating, dressing, hygiene, and other activities designed to improve his physical and psychological functioning
4. Stimulating the patient's participation in household activities
5. Guiding diversional and supportive activities for mental stimulation and constructive use of leisure time
6. Adapting the home to meet the needs of the patient
7. Teaching and, when necessary, supervising family members, other professionals, aides, and volunteers in carrying out selected aspects of the occupational therapy program
8. Assigning functions to and supervising occupational therapy assistants when they are available to the program
9. Participating in prevocational evaluation and planning along with others in the home care team and with other rehabilitation services, e.g., Vocational Rehabilitation.
10. Serving as liaison between the home care program and other community occupational therapy services or departments

When the therapist serves primarily as a consultant, he is most likely to:

1. Evaluate the patient's level of functioning
2. Establish a treatment plan in response to medical referral and patient

care goals established by the team

3. Obtain medical referral for occupational therapy
4. Instruct and supervise others in carrying out selected aspects of the treatment plan
5. Periodically evaluate the patient's status and progress
6. Consult with other team members, the patient, and his family
7. Serve as liaison between other community sources of occupational therapy and the home care program

Occupational therapists are most likely to be employed by those institutions or agencies offering rehabilitation services, as cited in Section IV on physical therapy. In addition, a psychiatric hospital or mental health center may be a resource for securing a part-time therapist.

Suggested Readings

A Guide to Comprehensive Rehabilitation Services to the Homebound Disabled. (Monograph No. 4.) Washington: National Association of Sheltered Workshops and Homebound Programs, Inc. U.S. Department of Health, Education and Welfare, 1961.

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Section 7

Speech Therapy

Speech therapy is desirable as a service within a home care program. Most speech therapists are employed by local or county school systems, rehabilitation centers, or college or university speech and hearing clinics, and relatively small number are in private practice. Their service may be available to a program on a limited basis.

The role of this therapist would be determined by his availability to the program. His functions in the program may include:

1. Assisting the physician in the diagnosis and evaluation of the patient's speech and language disorder
2. Developing a treatment plan with periodic follow-up and evaluation of the patient
3. Determining what changes are necessary in the treatment plan and when these should be made
4. Teaching and guiding others who will be carrying out selected aspects of the treatment plan
5. Consulting with the other team members and family members when necessary
6. Participating in in-service educational programs related to rehabilitation and speech and language disorders

Suggested Readings

Symposium for Audiologists and Speech Pathologists on Caring for Chronically Ill and Aged Patients. St. Louis: Training Center for Coordinated Home Care and Other Out-of-Hospital Health Services, Jewish Hospital of St. Louis, 1964.

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Section 8

Dental Services

Dental services for homebound patients are generally provided only for emergencies. This service can be provided in the home, dental office, outpatient clinic, or as an inpatient service of a hospital, but dentists prefer, whenever possible, to work in an office or clinic. Experience has shown that a large percentage of homebound patients can be treated in these traditional settings if suitable transportation is available.

Evaluation by a dentist should be a part of the total evaluation of hospitalized patients with chronic illness. When care is required, arrangements should be made for at least initial treatment and preferably for the complete course of treatment while the patient is still hospitalized. The patient's private dentist should be consulted in planning for dental care.

The home care program may or may not provide dental care as a part of its direct service. If it does not, the program may provide for:

1. Transporting the patient to and from the dental office or clinic
2. Stimulating the establishment of a community dental care program if none exists, including treatment for the nursing home and homebound patient
3. Establishing, with leadership from the local dental society or the health department's dentist, a roster of practitioners who are willing to make home calls
4. Developing a center to provide readily transportable equipment and a dental assistant

It is essential that the local dental society be actively associated with any planning of dental services, regardless of the scope of such programming. The local health department should be contacted for equipment or services that they may have available.

Dental Care in the Home

When care is provided in the home, modern, lightweight, and adequate portable equipment may be provided by the dental society, health department, hospital, dental school, if there is one in the community, or the home care program itself. The equipment should be centrally located, easily accessible to the dentist, and readily available.

Referral systems and scheduling methods must be developed, and it is essential that the patient's private dentist be consulted in planning the care. If the private practitioner does not see his patient in the home setting, a workable, efficient method must be established and maintained to keep him informed.

To provide dental services for patients on home care requires the selection of a dentist to act as liaison between the home care program and the dental society or community dental care program. The method of selection will depend upon the local situation.

The dentist in a coordinated home care program will:

1. Diagnose and treat oral conditions
2. Participate in evaluating the patient's total care needs and outline dental priorities as appropriate
3. Collaborate with the attending physician in planning dental treatment
4. Plan, with consultation with team members, methods of providing dental services
5. Share with the home care team pertinent information on the patient's dental status, response to treatment, and recommendations for future dental care

The Dental Hygienist

The dental hygienist is an important member of the dental team and should take part in any program for the homebound. Oral prophylaxis and oral hygiene often

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are the major needs of the chronically ill, and it is in these areas that the hygienist can be used effectively. One of her major responsibilities is instructing patients, family members, and other health professionals on oral hygiene. The dental hygienist, whenever possible, should be available to the program on a regular basis. She then can serve as the central person to provide continuity of effort in the dental program.

The hygienist may be employed full- or part-time by the home care program or be available as a part of contractual arrangements with a community dental service, e.g., community dental care program, health department, or private practitioner. If there is no hygienist currently employed that can participate in the homebound program, an inactive or part-time employed hygienist should be recruited.

The Dental Assistant

The dental assistant may be a volunteer or an employee with an adequate amount of formal or on-the-job training. Her functions may include:

1. Assisting the dentist in evaluation and treatment procedures
2. Accepting referrals for service and maintaining the schedule of home visits
3. Maintaining the dental records
4. Maintaining the equipment and sterilizing instruments

The assistant's employing agent will be determined by the local situation.

Suggested Readings

Dental Care for the Chronically Ill and Aged: A Community Experiment. (Public Health Service Publication No. 899.) Washington, D. C.: U.S. Government Printing Office, 1961.

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Dunning, James. Principles of Dental Public Health. Cambridge: Harvard University Press, 1962, pp. 464-472.

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Section 9

Home Health Aide and Homemaker Service

There is no precise delineation between the home health aide and the homemaker, as their functions overlap. Because of the nature of the training one person may serve both functions. For the purposes of this section the following definitions have been selected:

Home Health Aide:

> "Home health aides are unlicensed, nonprofessional workers who are prepared to assist the sick, disabled, or infirm at home when no family member is fully able to assume this responsibility. Neither nurses nor domestics, they are unique workers whose services are supervised by health personnel and provided as part of a continuing medical care plan."[1]

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[1] Home Health Aide Service in Relation to Public Health Nursing. New York: Department of Public Health Nursing, National League for Nursing, 1965, p. 7.

Homemaker-Home Health Aide Service:

> "Homemaker-Home Health Aide Service is an organized community program provided through a public or voluntary non-profit agency. Qualified persons - homemaker-home health aides - are employed, trained and assigned by this agency to help maintain, strengthen and safeguard the care of children and the functioning of dependent, physically or emotionally ill or handicapped children and adults in their own homes where no responsible person is available for this purpose. The appropriate professional staff of the agency establishes with applicants their need for service, develops a suitable plan to meet it, assigns and supervises the homemaker-home health aides and continually evaluates whether the help given meets the diagnosed need of its recipients."[1]

Home Health Aide Service

The home health aide is not a substitute for a professional nurse or practical nurse. She is a person whose functions are similar to those which could be performed by a knowledgeable family member. The activities the aide carries out are determined by agency policy, the aide's training, and her demonstrated abilities.

Medicare has established several conditions that must be met before an agency can be reimbursed for the services of an aide. The main points are:

1. The service is part of a medical care plan
2. The personal care activities carried out by the aide are determined by a registered professional nurse
3. Training of the aide in personal care services is given by a registered professional nurse with the other disciplines appropriately involved in the training
4. When the aide is providing personal care services, she receives direct supervision from a registered professional nurse

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[1] Standards for Homemaker-Home Health Aide Services. New York: National Council for Homemaker Services, Inc., 1965, p.5.

Administration

The home care agency may contract for this service from a public or voluntary community agency or offer this service under its own aegis. If a homemaker-home health aide service exists in a community, it should be used by the home care program. When service is obtained from a nonhealth agency employing the home health aide, the Department of Public Health Nursing of the National League for Nursing points out:

> "Agencies willing to work together cooperatively can develop a feasible plan and translate this into written agreements and statements of policies covering specific items. Following are major considerations:
>
> How applicants are admitted for aide service
> How needs of clients are evaluated and plans made
> Who decides the amount of time an aide is to be in a home
> Who decides an aides' duties - personal care duties and others
> What the scope and limitations of the health agency are in directing and supervising aides in homes
> Who supervises aides in functions other than personal care
> How do two supervisors mesh their responsibilities
> What steps are to be taken if the health agency feels an aide is functioning inadequately
>
> The health agency also will need to know such things as the size of the pool of services to which it will have access, methods of requesting service, time notification necessary before service can be initiated or terminated, geographical area to be covered, transportation methods to be used, legal responsibilities to be assumed by each agency, and billing and payment procedure."[1]

Selection

Specific written policies for selecting the home health aide should be established. Experience of programs offering home health aide service suggests the following criteria for selection:[2]

1. Ability to read and write
2. Ability to understand and carry out directions or instructions

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[1] Home Health Aide Service in Relation to Public Health Nursing. New York: Department of Public Health Nursing, National League for Nursing, 1965, p. 10.

[2] Items 1, 2, 3, 5, and 6 are specified in the Conditions of Participation for Home Health Agencies: Health Insurance for the Aged. (U.S. Department of Health, Education, and Welfare, Social Security Administration, HIM-2.) Washington, D.C.: U.S. Government Printing Office, 1966.

3. Ability to record messages and keep simple records
4. Evidence of good physical health
5. Emotional and mental maturity
6. Interest in and sympathetic attitude towrds caring for the sick at home
7. Willingness and ability to accept and benefit from supervision
8. Capacity for establishing a helping relationship with patients and families
9. Ability to adapt to a variety of situations
10. Some experience as a homemaker in her own home
11. Successful work experience as either a domestic or hospital aide, desirable but not necessary
12. Successful completion of a Red Cross home nursing course or nurses aide training course, desirable but not necessary

The selection of qualified applicants is critical to the success of the program, and a professional person, either a nurse or social worker, should be responsible for this.

Training

To date there is no standard curriculum for formal training of the aide. The Public Health Service will be publishing a manual for training of homemakers-home health aides in the fall of 1966. Medicare's Conditions of Participation for Home Health Agencies indicates content areas to be included in aide training and orientation. Experience indicates that on-the-job training with good supervision is more valuable than formal classroom instruction. The aide is often taught personal care procedures as they are needed in a particular situation.

Supervision

Supervision of the aide in personal care services is the responsibility of the professional nurse, who determines what activities can be assigned to the aide, teaches the aide, and supervises and evaluates her performance. The nurse should provide in-the-home supervision as well as be available to the aide by phone and in the office.

Activities

The activities of the aide would not be essentially different from those which she would perform in any other type of care-of-the-sick-at-home program. She would still carry out only those activities specifically assigned to her and would receive her supervision from the appropriate professional person. The aide would serve as a member of the team and share her observations of the patient and family, thus contributing to development and evaluation of patient care goals.

Homemaker Service

Homemaker service is distinguished from home health aide service, although an agency may carry both programs. The home health aide is placed in a home primarily to assist with personal care. The homemaker is placed in a home for the maintenance of household routine and the preservation or creation of wholesome family living in times of stress. Her role and functions are determined by the care plan established for the patient and family. The homemaker's selection, training, placement, and supervision are done by a professional person. The service may be sponsored by a public or voluntary health or welfare agency, or be available from an independent homemaker agency. The home care program may administer a homemaker--home health aide service or contract for this service from another agency.

Suggested Readings

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Doscher, Virginia R. Report of the 1964 National Conference on Homemaker Services. New York: National Council for Homemaker Services, Inc., n.d.

Hall, Madelyn. "Home Health Aide Services Are Here to Stay," Nursing Outlook, Vol. 14, June, 1966, p. 44.

Home Health Aide Service in Relation to Public Health Nursing. New York: Department of Public Health Nursing, National League for Nursing, 1965.

How to Operate a Community Homemaker Service. Chicago: American Medical Association, Council on Medical Services, 1963.

How to Plan a Community Homemaker Service. Chicago: American Medical Association, Council on Medical Services, 1961.

Lefson, Eleanor. "One Week's Training for the Home Health Aide," Nursing Outlook. Vol. 14, June, 1966, p. 48.

Phillips, Elizabeth. "Visiting Home Aide Program of Visiting Nurse Service of Rochester and Monroe County," Nursing Outlook. Vol. 10, May, 1962, p. 321.

Sargent, Emilie. "Detroit Home Aide Service," Nursing Outlook. Vol. 10, May, 1962, p. 318.

Standards for Homemaker-Home Health Aide Services. New York: National Council for Homemaker Services, Inc., 1965.

UNIT VI
ADDITIONAL HOME CARE SERVICES

Introduction

A wide range of services exist in the health and welfare community, which may be available to the home care program. These services include:

- Education
- Friendly visitors
- Meals
- Patient and equipment transportation
- Podiatry
- Psychology
- Recreational therapy
- Work-at-home programs

Other supplies and services that may be available are:

- Blood and intravenous fluids, electrocardiograms, laboratory tests, oxygen and oxygen therapy, diagnostic and therapeutic X ray
- Drugs, medications, and medical supplies
- Prosthetic appliances
- Sick room equipment (medical appliances)

Program objectives and the available resources determine which of these services are offered by the home care program. The home care program may find that there is insufficient demand to justify offering additional services under its own aegis, but occasional needs for these services should be met through contractual arrangements or agreements with existing local or state agencies or private practitioners or should be arranged directly by the patient or family. In these situations the home care program would serve primarily as an information, referral, and coordinating agent.

Friendly Visitors

A friendly visitor service in the community is an asset to meeting social needs of the aged and homebound. If such a service exists, the home care program should use it for its patients as appropriate. If there is no such service, the program may encourage an agency to assume the sponsorship and supervision of the service. The agency best suited for this purpose, either a volunteer bureau, welfare department, casework agency, senior center, YMCA, YWCA, or similar agency with professional direction, would depend upon the local situation.

Meal Service

Some communities have established a home-delivered-meals program to serve the aged and homebound with limited ability to obtain or prepare meals. If no such program exists in the community, the home care program may stimulate the establishment of such a service. If there is a meal service, the program should recommend it for its patients whose meals cannot be provided within their household.

To establish a home-delivered-meals program consider:

1. Methods of referral
2. Criteria for acceptance
3. The patient's special dietary needs
4. Method of financing and collection of fees
5. Qualifications of the nutrition personnel supervising the service

The home care program should make a written agreement with the meal service indicating conditions under which the service will be available to home care patients.

Transportation

The home care program may provide for transportation of patients or equipment with its own vehicles or through agreements or contracts with ambulance services, taxi companies, or volunteer motor pools. If no transportation service is available to the program, the program should assist patients and families in arranging transportation.

In providing transportation service consider these points:

1. Volume of need as justification of purchase or lease of vehicles
2. Insurance, maintenance, and repair costs
3. Availability of drivers and people to assist the patient or move equipment, e.g., hospital beds
4. Procedures for scheduling

Psychological Services

Work-at-Home Services

Educational Services

Podiatry

Recreational Therapy

Provision of Prosthetic Appliances

The home care program may or may not offer these services, since they are usually needed only by special groups or the need for them may be sporadic. The home care team should be aware of other agencies or practitioners willing to provide necessary service and use existing resources. The program would serve as an informational and referral source and coordinate the services with the overall plan for patient care.

Provision of:

Blood and Intravenous Fluids
Electrocardiogram
Laboratory Service
Oxygen and Oxygen Therapy
X Ray, Diagnostic, and Therapeutic

These services require the attending physician's order. Use of them for the home care patient will depend upon the prevailing practice in the community. They may be available only upon direct referral from the attending physician with the home care program having no control over the service. Lack of technical personnel, necessary equipment, or the specific procedures may preclude offering the service in the home. In these situations the program would function primarily in assisting the physician and family in arranging for the service.

Provision of Drugs, Medications, and Medical Supplies

The home care program may, under the attending physician's order, provide selected drugs, medications, and medical supplies to the patients on the program. Prepayment plans may include some of these as part of the home care benefits. The major responsibility of the home care program is to ensure that the drugs, medications, and medical supplies are obtained without delay and that economic barriers are eliminated or resolved.

Provision of Sick Room Equipment (Medical Appliances)

When care is provided in the home, need for adaptations of equipment normally in the home as well as additional equipment must be anticipated. The most commonly used equipment includes: wheelchairs, hospital beds, side rails, bedpans, urinals, crutches, canes, and walkers. Other supplies may include: commodes, back rests, lifts, bed boards, bedside tables, rubber rings, emesis basins, traction equipment, bed trays, sand bags, raised toilet seats, and suction equipment. The attending physician must be consulted prior to placement of certain equipment in the home. The physical therapist could serve as a consultant to the physician concerning whether the equipment would promote or deter rehabilitation.

The decision to loan, rent, or have the family purchase equipment should be based on:

1. Availability of equipment for loan or rental
2. Anticipated duration of need for equipment
3. Cost of equipment in relation to purchase or rental

Loan closets may be sponsored by health or welfare agencies, civic or church groups, fraternal organizations, or other community agencies or groups, with or without a rental charge. Rental of equipment through commercial supply houses is possible in many communities. The home care program may wish to establish a loan closet for the use of its patients; however, a central closet for the use of the entire community is a more desirable plan.

In establishing and administering a loan closet consider:

1. Kinds and numbers of equipment to be available
2. Methods and cost of obtaining equipment
3. Sources of financing initial purchase, maintenance, and replacement of equipment
4. How and where equipment will be stored
5. Identification of equipment
6. Records of equipment loaned or rented, to whom, date of delivery and return
7. Transportation of equipment
8. Personnel and arrangements necessary for sterilization, cleaning, repair, and maintenance of equipment.
9. Procedures for obtaining equipment for patients
10. Fees and charges

Volunteers

Volunteers are an asset to any program and may contribute in a variety of ways. They may:

1. Assist with clerical or administrative routines
2. Conduct messenger services
3. Coordinate services such as friendly visitors, transportation, loan closet
4. Participate in services by delivering home meals, serving as friendly visitors, assisting with transportation as driver or motor pool assistant, assisting with the dental program, etc.
5. Provide "sitting" service to relieve family members for stated periods of time

Selection, orientation, and supervision of volunteers is the responsibility of the agency using their services. The home care agency should designate a person to be responsible for coordinating the volunteer services and schedules and budget time and personnel for recruitment, selection, training, and supervision of volunteers. Recognition of the volunteers contribution is extremely important. Retirees often are willing and able to provide such services, or some communities have a centralized volunteer service or bureau, which can be used by the home care program.

Suggested Readings

Friendly Visitors

Byron, Evelyn. Patterns for Progress in Aging: A Friendly Visiting Program. (Office of Aging, Publication No. 183.) Washington, D.C.: U.S. Government Printing Office, 1961.

Home-Delivered Meals

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Transportation

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Volunteers

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UNIT VII

PLANNING PATIENT CARE

Introduction

Planning patient care is a continuous process and should be undertaken not only when there is need to change the location of the patient, but also from the beginning of care. Continuous planning and evaluation are imperative to maintaining a high level of care.

The ultimate responsibility for planning patient care rests with the attending physician. All of the health professions can assist him in development and implementation of the plan. Home care is one phase in medical care available to a patient, not a substitute for other types of care, and the services available through the program may not meet the patient's most crucial needs. However, the physician must be aware of what the program can offer to his patient, as well as which patients can be served. The attitudes and abilities of members of the household and the home conditions are important factors in considering the appropriateness of home care for a particular patient.

Patient Selection

In the past, patients have been selected on the basis of:

1. Age
2. Financial situation
3. Diagnostic category
4. Degree or level of illness, e.g., acute, chronic, convalescent, terminal
5. Functional level, i.e., degree of independence in activities of daily living and potential for improvement
6. Place of residence

However, the use of these criteria has restricted the number of home care patients, omitting some who might have benefited from a coordinated home care program.

The number and type of patients admitted to the program will be influenced by the program's objectives, the physician's willingness to use the program when appropriate, and the staff and kinds of services available.

Patient selection should be based on:

1. The patient's medical status:
    a. Treatment in the home is adequate and can be safely administered
    b. Constant care and observation are not required
    c. Though intensive care is not necessary, service on an ambulatory or outpatient basis is inadequate
    d. An adequate clinical evaluation has been made within a specified time
2. Willingness of patient and family to participate in home care
3. Availability of a responsible person (care-taking person):
    a. Who understands or can learn the care needed
    b. Who can actively participate in giving care
    c. Who is physically and emotionally able to give necessary care 24 hours a day, 7 days a week, or can make acceptable arrangements for ongoing care
    d. Who is available on an extended basis
4. Availability of a home for the patient in which care can be safely given without physical or emotional harm to the patient, family, or care-taking person, such as:
    a. the patient's residence
    b. the residence of a relative or friend
    c. a foster home
    d. a boarding home

The home care program staff should maintain a record of referred patients not accepted for service. Analysis of these referrals may reveal:

1. Changes or revisions of criteria are indicated
2. Certain services that are repeatedly requested but not offered by the program
3. Lack of understanding of the program by the professions and community
4. Appropriate use of available resourses

When such information is collected and analyzed, the staff can use it to:

1. Validate the need for adding services to the program when seeking additional financial support for new services
2. Stimulate community planning to fill gaps in services
3. Assist in evaluation of the program

Alternatives for Care

The physician has responsibility for deciding what type of facility would best meet his patient's care needs. When a patient is not accepted by the home care program, the program staff should assist the physician, patient, and family in making other arrangements.

Planning alternatives involves:

1. Physical and emotional status of the patient
2. Rehabilitation potential of the patient
3. Complexity and intensity of care needed
4. Costs and financing of other care arrangements
5. Patient's and family's acceptance of and consent to other care arrangements
6. Availability and accessibility of other care resources
7. Anticipated duration of stay

Types of facilities available for care are:

1. General hospital
2. Special hospital, e.g., chronic disease, psychiatric, or sanatarium
3. Extended care facility
4. Nursing home
5. Home for the aged
6. Children's residential treatment or training center
7. Rehabilitation center
8. Ambulatory, e.g., outpatient clinic, physician's office, and day-care programs
9. The home, when the family and physician can provide all the necessary care

Selection of the appropriate facility depends upon:

1. Level of care the facility can provide and the services available
2. Nature of the patient's condition, prognosis, and anticipated duration of need, e.g., temporary, short term, long term, or indefinite
3. Accreditation or certification of the institution or agency recommended
4. Admission policies of the facility, criteria for patient selection, and waiting period for admission

Referral Systems

The critical factor in any program for continuity of patient care is the prompt transmission of pertinent information among the agencies and services involved. A patient's needs may be identified and validated, but the process can be in vain if referrals are not made to the available services that can meet these needs.

Some of the problems in referral systems are:

1. Lack of information concerning available resources
2. Delays in initiating referrals due to:
    a. Last minute planning
    b. Other immediate pressures of the referring agent
    c. Lack of understanding of the need for referral

3. Needless complexity in referral systems and forms
4. Inadequate information given by the referring agent
5. Lack of reporting back to the referring agent

Methods of referral, including referral forms, should be developed jointly by the agencies to be involved. These methods must provide efficient, speedy transmission of pertinent information without duplication of effort and requiring a minimum of time for completing the referral. This system should include methods of reporting as well as referring. A community-wide referral form has been developed in some communities that is used by hospital and community health agencies and could be used by extended care facilities and nursing homes. The content of the form should include information that is necessary for records for third party payers, including Medicare.

Team Care

The use of teams in providing health services is expanding rapidly. These may be composed of:

1. A group within the same profession, or representing two or more professions (multidisciplinary)
2. Nonprofessionals working with a professional person
3. Technicians working with a professional person
4. A patient and family working with a professional person

Coordinated home care is based on the concept of a multidisciplinary team, with the roles of each of the professionals supporting the team.

The presence of several disciplines does not necessarily mean that the individuals function as a team. Although the administrative and professional environment may foster the team concept, deterrents do exist. In order to effectively plan and evaluate patient care the members of the team must:

1. Establish communication among the professions
2. Define clearly the professional roles
3. Be willing and able to establish attainable goals for the patient and

family through professional evaluations and reaching agreement on desired outcomes

As a result of this process no one discipline works in isolation, and each contributes to the overall treatment plan.

Team Leadership

The attending physician is responsible for establishing the medical care plan. He heads the team in relation to his patient and calls upon the appropriate disciplines to assist in carrying out the treatment plan.

During the course of treatment for a given patient, the leadership of the team may be provided by either of the team members, although the physician remains in charge of the treatment plan. At any point the social, rehabilitation, or nursing needs of the patient may become the primary focus of care. Leadership for developing and carrying out the medically directed treatment plan may then be assumed by the appropriate professional person.

Team Conference

The team conference is an effective way of exchanging information, establishing care goals, and evaluating movement toward these goals. In the conference communication between the various members must be established and maintained. The frequency of team meetings may vary; however, in order for the team to be effective these conferences should be held on a regular basis.

The Role of the Family

Up to this point emphasis has been placed on the administrative and professional aspects of home care. However, without the acceptance, understanding, and participation of the patient and family, the home care team might better spend its time pounding sand down a rat hole.

The team must realize that professional service is only available to the patient and family on a part-time basis. The patient and family carry the greatest share of implementing the home care plan. Because of the critical part the patient and family take in home care, they must be actively involved in the planning and evaluation of care, and the stated goals must be reasonable and acceptable to all involved.

The team is responsible for teaching and supporting the patient and family members in carrying out the home care plan. The patient and family must know whom they can contact and when, what to do in the event of an emergency, and which responsibilities are theirs and which ones will be carried out by the various team members. The patient and family must be considered members of the home care team.

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Planning for Long-Term Patient Care. St. Louis: Training Center for Coordinated Home Care and Other Out-of-Hospital Services, Jewish Hospital, January, 1963.

Selected Papers from the Physician and Hospital Home Care: A Scientific Seminar for Physicians, Part II. Pittsburgh: Home Care Department Training and Information Center, Montefiore Hospital Association of Western Pennsylvania, 1963.

Survey of Coordinated Home Care Programs. A Cooperative Project of the American Hospital Association, American Medical Association, Blue Cross Commission, Blue Shield Medical Care Plan and Public Health Service. (Public Health Service Publication No. 1062.) Washington, D.C.: U.S. Government Printing Office, 1963. A resurvey, in press (Fall, 1966), will replace this publication.

Weeks, Lewis E., and Griffith, John R. (eds.). Progressive Patient Care: An Anthology. (Research Series No. 3.) Ann Arbor: Bureau of Hospital Administration, School of Business Administration, The University of Michigan, 1964.

Chapter 27: "Patients on Home Care: Their Characteristics and Experience," Franz Goldmann and Marta Fraenkel.

Wensley, Edith. Nursing Service Without Walls. New York: National League for Nursing, 1963.

UNIT VIII

FINANCING COORDINATED HOME CARE

Introduction

Financing any program, including home care, is a critical aspect of planning and administration. Financing includes finding sources of support, budgeting, and fiscal management. Since there is no uniform system of reporting costs among home care programs, fiscal comparability of programs is extremely difficult. Therefore, this unit will focus on general considerations in financing a program.

Sources of Income

All possible sources of income should be explored. Commitment of necessary funds must be guaranteed prior to the initiation of the program. If short-term funds are obtained for a demonstration period, possibilities of continued support should be ascertained prior to initiation of the program. The sources of support may include:

1. United Funds or Community Chests, foundations, and local tax monies
2. Voluntary health agencies, such as Cancer Society, Heart Association, Society for Crippled Children and Adults, and the National Foundation
3. Insurance (including Workman's Compensation) and prepayment plans
4. Governmental programs, i.e., Medical care under the Social Security Act, public welfare, Veterans' Administration, Vocational Rehabilitation, and state services for crippled children
5. Grants-in-aid or support from state and federal agencies (health or welfare departments)
6. Patient fees

Many coordinated home care programs were initially financed by project or demonstration grants from state health departments, the Public Health Service, or private foundations. However, if a program seeks and obtains short-term funds to become operative, planning for support upon termination of these funds must begin at the outset of the program. State health departments may provide long-term program support but often can only offer assistance to local health departments for special purposes. Usually private foundations and the Public Health Service do not provide continuing program support beyond the project or demonstration phase.

Voluntary health agencies concerned with a specific illness or condition may support services for their clients, and other private and public programs may finance services for their clients.

Insurance and prepayment plans may include home care as a benefit under specific conditions. Programs must be alert to explore whether or not home care benefits are available to patients who carry individual or group policies with commercial insurance companies. Some home care agencies have found it helpful to have someone within the agency who knows about the various insurance policies and can assist staff members and administration in determining and verifying coverage of services.

A few Blue Cross plans include home care as a benefit. These benefits are usually an extension of hospital benefits and require that hospital days are saved and that home care is directly related to and necessary for the condition for which the patient was hospitalized. Blue Shield participation in home care is yet in the experimental stage and very uncommon. Group practice and other types of prepayment plans may offer home care benefits and should be explored by the program.

Governmental programs have been and will continue to be an important source of financing. Many states have paid for home care services under the public assistance programs such as Old Age Assistance and Medical Aid to the Aged. The Social Security Amendments of 1965 provide for reimbursement for home health services under Title XVIII. Home health services are not required under Title XIX, but states may elect to include these in their plans. The state plan to implement Title XIX may radically alter the eligibility for and financing of health care for public assistance recipients, the medically indigent, and other categories of low income persons. Home care programs must be informed of what services will be covered by these state administered programs.

Other governmental programs, such as Vocational Rehabilitation, Veterans Administration, and state services for crippled children, may include home care services. Again, the home care program should explore reimbursement for services provided to patients under these programs.

Patient fees are another source of income for a program. The stated charge should be the actual cost of service, and may be charged by units of service (visits), hours or days of service, or a rate covering a stated period of time. It is generally felt that a visit charge is most equitable for the recipient of service as well as the provider. When the patient and family must assume the full responsibility for payment of home care services, programs should establish a sliding scale or adjust fees for those patients unable to meet the full cost. The program should provide for recovering losses from part or no-pay patients and from bad debts.

The source of payment for home care services should not be a criterion for patient selection or duration of service. Third party payers establish standards of eligibility and set limitations on the kind and amount of service for which they will pay. However, care needs of patients may extend beyond their benefit coverage and their ability to pay, and United Funds or Community Chests may be asked to allocate funds to the program to defray such deficits. Prior to making such requests, the program must have explored all other possible sources of financing.

Fiscal Planning

The administrative agency should seek advice when developing the fiscal plan. Public agencies should consult with the appropriate public official, i.e., budget commissioner and comptroller or auditor, and voluntary agencies should consult with the budget director of the United Community Service or Community Council, if one exists. The voluntary agency should have someone with special knowledge in fiscal management on its board of directors, employ a qualified bookkeeper, and have accounting consultation or personnel available. Other sources for consultation include state health and welfare departments, the American Hospital Association, National League for Nursing, and fiscal intermediaries in the Medicare program.

Third party payers should be included in planning a home care program. Their commitment to reimburse the program for services provided to their clients or beneficiaries should be obtained before the program becomes operational. Written agreements or contracts should include the basis for determining the fee and methods of payment. For Medicare, arrangements should be made with the fiscal intermediary or, if the agency elects, directly with the Social Security Administration. Third party payers reimburse for services after they are rendered. Therefore, in fiscal planning, programs must develop methods for prefinancing if a delay in payment is anticipated.

Budgeting

The home care budget, which must be based on a realistic estimation of expected income, states the functions of the program in terms of costs, provides the means for wise expenditures of available resources, and aids in estimating future needs and resources.

Development of a budget for a home care program will depend on the procedures of the administering agency. Items usually included in the budget are:

1. Salary:
    a. Regular salaries, i.e., professional, secretarial, and other

part-time salaries including accounting and auditing

   b. Emergency help
   c. Fringe benefits

2. Office supplies and equipment
3. Overhead:
   a. Telephone
   b. Utilities, i.e., heat, light, water, etc.
   c. Rent
   d. Janitorial services
   e. Repairs
4. Transportation
5. Medical supplies (nursing, physical therapy)
6. Fees to other agencies for services contracted for by the program

Accounting

The home care program must include methods for complete and accurate accounting of expenditures and income. In a multiple program agency the accounting method used must facilitate the determination of the direct and total cost of the home care program. This is of particular importance for determining reimbursement rates and fees charged to patients, and for the separate accounting and auditing required by third party payers. The accounting method used by the home care program will be determined by the administering agency.

Determining Costs

One of the grave problems in some programs has been the lack of information about actual costs of providing home health services. Third party payers require that the fee be based on cost analysis. If a program is to be on a sound fiscal basis, it must know the costs of its services and base its charges upon these costs. If charges are set below actual costs, the program may jeopardize its continued existence. Third party reimbursement is often made according to costs or charges, whichever is less. Under Medicare, reimbursement of reasonable costs is made. If an agency makes no charge, it is not usually eligible for reimbursement by third party payers.

Costs are determined through cost studies or cost analysis. Guides are available from the American Hospital Association, National League for Nursing, and the Public Health Service.[1] Cost analysis involves:

1. Complete and accurate accounting of expenditures and income
2. Accurate statistical reporting with work units clearly defined and mutually exclusive
3. Accurate information of the use of time

Direct service costs and overhead expenses or indirect costs should be identified and calculated to arrive at the total cost of service.

New programs with low caseloads will have high costs. As the caseloads increase, the administrative costs are distributed over a larger base. However, an actual reduction in total costs may not occur with program expansion because of salary and cost increases and the additional staff required. A comprehensive program is not an inexpensive program at any stage of development.

Billing and Collection

Sound methods of billing and collecting monies for services rendered is a part of fiscal management. Programs may arrange to have centralized billing procedures within the agency with minimal staff involvement. Procedures for billing, collecting, and accounting for fees must be understood by the staff members, patients, and families and their responsibilities clearly identified. Billing and collection procedures with third party payers should be a part of the written agreements developed between the agencies. In health department administered programs, funds collected for home care services should revert back to the program rather than be put into the general funds of the local government (city or county).

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[1] See Suggested Reading List.

Accountability

Accountability for funds received is the responsibility of the program and administering agency. Fiscal records must be kept current, accurate and available for audit. Financial reports should be made available to the governing bodies and the community in general.

Suggested Readings

Conditions of Participation for Home Health Agencies: Health Insurance for the Aged. (U.S. Department of Health, Education, and Welfare, Social Security Administration, HIM-2.) Washington, D.C.: U.S. Government Printing Office, 1966.

Cost Analysis for Public Health Nursing Service. New York: National League for Nursing, 1964.

Cost Findings for Hospitals. Chicago: American Hospital Association, 1957.

Costs of Services to Patients at Home: Report of a Study in Six Health Agencies. Lansing: Michigan Department of Public Health, 1964.

Furguson, Marion. *How to Determine Nursing Expenditures in Small Health Agencies*. A Joint Project of the Public Health Service and the National League for Nursing. (Public Health Service Publication No. 902.) Washington, D.C.: U.S. Government Printing Office, 1962.

Home Health Agency Manual. (U.S. Department of Health, Education, and Welfare, Social Security Administration, HIM-11.) Washington, D.C.: U.S. Government Printing Office, 1966.

Littauer, David et al. Home Care. (Hospital Monograph Series No. 9.) Chicago: American Hospital Association, 1961, pp. 59-63, 86-92.

Principles of Reimbursement for Provider Costs. (U.S. Department of Health, Education, and Welfare, Social Security Administration, HIM-5.) Washington, D.C.: U.S. Government Printing Office, 1966.

Striegel, Bernardine. "Public Health Nursing in Major Medical Expense and Comprehensive Insurance," Nursing Outlook, Vol. 9, November, 1961, p. 692.

Uniform Chart of Accounts and Definitions for Hospitals. Chicago: American Hospital Association, 1959.

UNIT IX

RECORDS

Introduction

Record systems are vital. The value of adequate, accurate records cannot be underestimated, as they provide information for:

Administrative management
Program reporting, evaluation, and planning
Patient identification and services
Continuity and comprehensiveness of patient care
Evaluation of the quality of patient care
Cost accounting
Establishment of reimbursement rates
Budget planning
Personnel management
Professional education
Research

All aspects of record systems needed by agencies or institutions cannot be identified and discussed here. The agency administering the coordinated home care program is assumed to have an established record system, and the records developed for the program are an addition to or modification of what already exists.[1] The discussion in this unit relates to the record needs of a coordinated home care program.

To date there are no standardized definitions and policies for reporting data for coordinated home care programs. Therefore, statistical comparison of programs is difficult. The information collected must be current, complete, and accurate with well defined terms to obtain comparable data on all cases. In addition, only information that can and will be used should be collected. As record systems are developed or revised, the potential for data processing systems should be considered. Some communities may have such facilities.

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[1] An agency organized for the specific purpose of providing coordinated home care would need to develop a total record system.

Types of Records

The actual forms used by a program depend upon that program's need. They should include all of the information desired and required, be as simple to maintain as possible, be uniform in relation to categories or classification of information, and maintain the information in a readily retrievable form.

Individual Patient Records

Individual patient records are maintained by the professional staff providing the service. These records include:

1. Identifying data, e.g., name, address, age, sex, next of kin, and identifying numbers, i.e., agency and social security
2. Date and source of referral
3. Source of payment and fee or rate
4. Place of hospitalization, duration of hospitalization, and pertinent medical information regarding hospitalization[1]
5. Date of admission to and discharge from home care
6. Name of the attending physician
7. Written physician's orders
8. Clinical data, e.g., medical history, diagnosis, services needed, drugs, diet, and activity level
9. Written treatment plan and care goals
10. Services rendered and name of service person
11. Observations

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[1] Applies to institutional care of any sort.

12. Movement towards established goals
13. Pertinent data relating to the socio-economic situation that influence care
14. Date of and pertinent information resulting from team conferences
15. Periodic summarization of services rendered and patient response
16. Discharge summarization including reason for discharge, patient status on discharge, and disposition of the patient

When the home care program contracts for professional services, the mechanics of maintaining a multidisciplinary record must be developed so that the patient's record includes necessary and desired information. The use of dictating machines by professional staff helps conserve time.

Written policies for records should be developed and made available to all team members, or a record manual should be used. Such policies or manuals include definitions of terms, explanations of forms, delineation of responsibility for record maintenance, and guides for record content. The legal requirements for clinical records must be incorporated into the policies and records themselves.

Administrative Records

Administrative records are maintained to provide patient service and cost information. These records are the responsibility of the administrator or administrative team of the program. The records, which are summarized at regular intervals, usually on a monthly basis, include information on:

1. Characteristics of patients served, e.g., age, sex, diagnostic classification, geographic location
2. Type of services rendered
3. Providers of service
4. Sources of payment

This information, when summarized, indicates which categories of patients need what kinds of services, how much of these services was needed and how payment for these services was made.

The method for obtaining this information is selected by the program. Daily reports are often utilized. Whatever the method, clear definitions of terms and categories are needed. The staff members need to know how to complete the necessary forms and to do so accurately.

The record of staff time per case or per activity may or may not be needed on an ongoing basis. Often this information is obtained only for specified time periods in relation to cost and time studies. When the program is contracting for services or hiring personnel on a part-time basis, time records for these staff members must be maintained.

Program activity records are kept to show services and functions of the program and its staff. Information not specifically related to a patient should also be collected. Activities relating to team conferences, educational programs, consultation to other programs or agencies, professional meetings, and the like can then be identified, and it may be desirable to keep account of time spent in such activities.

Financial Records

Financial records may or may not be the direct responsibility of the program administrator. Usually agencies designate a person to maintain the records for all of the agency's programs. The financial information of direct concern to the program includes:

1. Costs of services, direct and indirect
2. Payments from recipients of service and third party payers
3. Payments to other agencies or individuals for contracted services
4. Operational needs such as supplies, equipment, and travel

The methods used for accounting determine what records are necessary and how they are to be kept.

Special records or modifications of records reflecting the nature of the information to be obtained, may be developed for studies or research. It is generally agreed, however, that record systems should be developed to provide information for sound administration and quality patient care rather than in anticipation of research or special studies. Too much information may be as hazardous as insufficient information.

Suggested Readings

Conditions of Participation for Home Health Agencies: Health Insurance for the Aged. (U.S. Department of Health, Education, and Welfare, Social Security Administration, HIM-2.) Washington, D.C.: U.S. Government Printing Office, 1966.

Home Health Agency Manual. (U.S. Department of Health, Education, and Welfare, Social Security Administration, HIM-11.) Washington, D.C.: U.S. Government Printing Office, 1966.

Public Health Nursing Service Manuals: A Guide for Their Development. New York: National League for Nursing, 1955.

Statistical Reporting in Public Health Nursing. New York: National League for Nursing, 1962.

UNIT X

EVALUATION

Introduction

This unit, in many respects, is a summation of the previous units. Evaluation, which is inherent in all aspects of home care presented, is a tool used to periodically review the work and bring about improvements when indicated. The evaluation is made to find weaknesses or failures and bring about corrections so as to better attain predetermined goals. Evaluation is also used to identify the level of care being given, provide information to purchasers of service, obtain community financial support, and provide information to physicians as to what can be accomplished for patients.

Evaluation is the process of measuring:

1. Effectiveness, i.e., the extent to which work accomplishes what it is intended to accomplish
2. Efficiency, i.e., the comparison of program effectiveness to the cost of attaining the objectives.

Therefore, those persons responsible for evaluation must be prepared to ask and answer the following questions:

1. Were the objectives clearly stated in terms of:
    a. Who: the individuals, program, or community
    b. Where: the geographic area
    c. What: the desirable condition or results
    d. How Much: the expected degree of attainment
    e. When: the time limit for attainment
2. Were the objectives achieved?
3. If the objectives were not fully achieved, what was the level of attainment?

4. What were the reasons for lack of full achievement?
    a. Were the objectives too general and vague?
    b. Were they unrealistic and impossible to achieve? This may result from inexperience in dealing with a given problem; inadequate consideration of attitudes and values of the community, patients, or families when setting objectives; or overemphasis on the values and ends proposed by one agency, discipline, or individual.
    c. Were the resources lacking?
    d. Were the resources available but improperly or inefficiently used?
5. Were the observed results due to program activities or to some external factors?
6. Were the observed results achieved in the most efficient way or can more efficient methods of achieving the same results be found?
7. Were the objectives the most appropriate ones or was there failure to consider the nature of the population being served, the needs of that population, or the lack of resources or knowledge for meeting such needs?

Evaluation should be carried out in terms of activities and objectives. Did the activities selected achieve the objectives set? It is necessary to look at what was actually done, what these activities accomplished, and how these accomplishments relate to what was planned.

In coordinated home care this evaluation process is applied to the care received by individual patients and to the total program. The basis for evaluation of either is a clear statement of goals or objectives that can be measured. Then methods for measurement must be developed and defined, and the frequency of evaluation and the responsibility of those involved in the process should be determined.

Evaluation of Patient Care

Any medical care program should be concerned with the quality and continuity of patient care as well as achievement of the program's objectives. High quality of care should, in fact, be inherent in the program.

Before a patient is admitted for home care service, it is necessary to:

1. Define and apply the criteria for patient selection
2. Identify the goals achieved for patients with similar conditions in the past as determined by experience and clinical judgment
3. Consider the services and resources of the program available for patient care
4. Define and apply the criteria for discharge from the program.[1] These factors will influence the goals established for a given patient.

After the patient is admitted, goals for his care should be established by the care team with agreement on and understanding of expected outcomes. These goals should be recorded, and criteria for measuring effects of care must then be defined and applied. For valid measurement it is imperative that the criteria be uniformly applied not only in measuring effects, but also in selection and discharge of patients. Clearly defined terms that have the same meaning for a multidisciplinary group are necessary.

The methods of measuring the effectiveness and efficiency of care include:

1. Professional review: How did judgments made and actions taken measure up to the professional standards of practice, e.g., medical and nursing audits?
2. Individual case record review: What was done for the patient, at what point in time, by whom, under what circumstances, and what was the patient's response?
3. Service statistical review: How many visits were made to which patient, how long were which services provided, what treatments were given, and at what frequency?

In coordinated home care, evaluation of patient care is a team evaluation rather than the responsibility of just one discipline or person. The team, in establishing care goals, commits itself to evaluating the attainment of these goals. However, problems within the team may interfere with the goal establishment, the evaluation process, and determination of readiness for discharge. These problems, which may relate to the professional status of team members, personal reactions to individual patients, or communication barriers among the various disciplines, must be recognized and resolved.

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[1] Unless criteria for discharge are established and applied, patients may be served longer than is appropriate, indefinitely, or until third party payment ceases.

Program Evaluation

The basis for program evaluation is the same as previously stated: clearly defined objectives stated in measurable terms. The process is to measure effectiveness and efficiency, and the scope is the total program, rather than one patient. Periodic program evaluation will show whether activities are appropriate to the stated objectives and whether these objectives are realistic.

In order to evaluate a program, standards or criteria must be developed or defined and applied uniformly by those responsible for evaluation.

The methods of evaluating a program's effectiveness (numbers 1-6) and efficiency (number 7) include:

1. Record review: random sampling for evaluation of quality of care, which may be done by persons outside the program
2. Statistical review: volume and characteristics of services, patients, and costs; distribution of patients, staff, and costs
3. Referral review: requests for services available through the program, characteristics of patients not accepted for care; sources of referral and time elapse between referral and initiation of service
4. Analysis of professional functions: the actual functions of the staff in relation to their professional skills
5. Analysis of attainment of individual patient care goals: the sum of the goal attainments for all patients to provide a measure of attainment of the program's objectives

6. Patient discharge statements: reasons for discharge, status of the patients upon discharge, and length of stay in the program
7. Cost analysis: efficiency in relation to costs of services provided and costs of objectives attained

Evaluation of individual patient care and total program is basically relating input (care) to output (objectives). It tests the assumptions made in planning that certain objectives or goals will be achieved by carrying out certain activities. Evaluation is the preamble to future planning, for it will show if there is a need to change activities, modify objectives, or correct false assumptions. Evaluation is a process that is vital to sound planning, financing, and verification of the value of home care.

Suggested Readings

A Guide to Medical Care Administration: Concepts and Principles, Vol. I. New York: The American Public Health Association, 1965, pp. 61-65.

Kasten, Jack. "The Case for Standards in Home Care Programs," The Gerontologist, Vol. 3, March, 1963, p. 14.

Perrow, Charles. "Research in a Home Care Program," American Journal of Public Health, Vol. 49, January, 1959, p. 34.

Phaneuf, Maria. "The Nursing Audit for Evaluation of Patient Care," Nursing Outlook, Vol. 14, June, 1966, p. 51.

Procedures for Evaluating Health Programs, 6th revision. Ann Arbor, Mich.: Department of Community Health Services, School of Public Health, The University of Michigan, November, 1965.

Roberts, Doris. How to Study Patient Progress. Washington, D.C.; U.S. Government Printing Office, 1964.

APPENDIX A

CONDUCTING THE TRAINING COURSE

The Manual

This manual has been developed as a guide for content of a short-term course on coordinated home care. The material presented covers planning, organizing, implementing, and evaluating home care programs. Modifications in sequence or emphasis should be made as desired. Suggested readings that deal with or relate to the content are included in each unit and are appropriate for the trainer and trainees.

Planning Committee

One person should be designated as course coordinator by the sponsoring agency. A planning committee should be organized to assist the sponsoring agency and coordinator in planning the training course and to offer suggestions and guidance regarding:

1. Training needs to be met
2. Scope and emphasis of training
3. Objectives of the course
4. Number and selection of trainees
5. Date or dates of training sessions and time per session
6. Methods of evaluating the training course
7. Financing of the course
8. Speakers to be invited to participate
9. Use of field trips

Committee members should include persons with experience in a coordinated home care program, administration, and educational activities and represent the various disciplines. The persons selected should have appreciation for training needs beyond their particular agency or institution.

The Trainees

During the planning phase the criteria for selection of trainees must be decided. The course may be planned for a single or multidisciplinary group, for personnel at the administrative or staff level, or for those experienced in provision of home health services or without such experience.

The number of trainees accepted will depend on the objectives of the course, the physical accommodations, the type of training planned, and the cost and financing of the training.

Course Content

The content of the course may be modified to meet the objectives set by the sponsoring agency and planning committee. The audience for the course, i.e., single or multidisciplinary, experienced or inexperienced, administrators or staff, will influence the emphasis given to particular areas of material.

Various teaching methods can be used to attain different objectives. These methods include:

1. Lectures to impart factual information and concepts
2. Discussion groups to assist trainees in identifying and understanding concepts and information through participation in the process of problem solving
3. Case studies to assist trainees in applying concepts and information to specific situations, and in identifying concepts and principles of wider applicability from specific situations
4. Observations and demonstrations to assist the trainee in direct application of content by discussing the experience and raising questions concerning its applicability

The availability of staff and materials, the number of trainees, and the course objectives must be considered in determining the methods to be used. Training materials available through the Home Care Training Centers are given in Appendix B. Audio-visual aids may be used in either lectures or discussion groups to illustrate or reinforce material under consideration or stimulate discussion.

Once the content, faculty, and audience have been determined, the course must be publicized. This may be done by notifying appropriate agencies, institutions, and professional journals and through personal or group contacts well in advance of the scheduled course.

Administrative Considerations

The cost of conducting a training course must be estimated and methods found for meeting the costs. Items to be considered are:

1. Program printing
2. Course promotion
3. Postage
4. Rental of classroom space, if necessary
5. Transportation for field trips
6. Coffee and refreshments
7. Honorarium and travel expense for speakers, consultants, or resource persons
8. Clerical services and supplies
9. Educational materials
10. Registration materials
11. Rental of audio-visual aids

Methods of financing include tuition or registration fee, special training grants, funds from private resources, or a combination of these. If tuition is charged, the amount should be made known, and methods for collecting and accounting established.

The physical setup should be planned in relation to physical comfort, acoustics, lighting, and ventilation. The methods of teaching and the number of trainees will determine the number of rooms necessary. Consideration must be given for trainees who will need housing. The sponsoring agency should decide if it will secure housing or merely make known the type, cost, and location of available accommodations.

The amount of time and dates for training sessions must be established with the assistance of the planning committee. The course may be given in a block of time or extended over a period of weeks. Each unit can be modified so that the entire course can be given in 20 hours or less.

Field trips may be planned for an entire day, half day, or encompass visits to several programs over a period of time. The objectives of field trips should complement the course content. Further discussion of field trips is included in Appendix C.

APPENDIX B

RESOURCES FOR TRAINING MATERIALS AND CONSULTATION

Those planning a training course in home care may wish to obtain consultation or teaching materials for the development of the course. Consultation may be desired relating to:

1. The content to be presented in the training program
2. Educational aspects of conducting training programs
3. Evaluation of training programs

There are, as of this printing, seven home care training centers in the United States. These centers have experience in training activities and have developed selected teaching aids. The list of centers, their addresses, and some of their publications and visual aids are cited, and other possible resources are also given. This listing is not exhaustive, and other resources may exist which can be of assistance in training. Inquiries should be made directly to the institution, agency, association, or program. There may be charges for consultation and training materials, and this should be discussed at the time the inquiries are made.

Home Care Training Centers

The Jewish Hospital, St. Louis
Training Center for Coordinated Home Care and Other Out-of-Hospital
Health Services
Publications: Rehabilitation Nursing, manual
Home Care Newsletter, newsletter

Proceedings:

The Principles of Home Care

Workshop on Evaluation of Patient Care in Home Care Programs

Planning for Long-Term Patient Care

Symposium on Research in Long-Term Care

Social Workers and Long-Term Care

Symposium for Audiologists and Speech Pathologists on Caring for Chronically Ill and Aged Patients

Audio-visual aids: "The Hospital Extended," 35 mm slide series

Address: Coordinator, Training Center for Coordinated Home Care and other Out-of-Hospital Health Services
The Jewish Hospital of St. Louis
216 South Kingshighway
St. Louis, Missouri 63110

Massachusetts Department of Public Health, Bureau of Chronic Disease
Training Center for Comprehensive Care

Publications: Selected papers available

Address: Director, Training Center for Comprehensive Care
Lemuel Shattuck Hospital
170 Morton Street
Jamaica Plain, Massachusetts 02130

Montefiore Hospital, New York City
Training Programs in Home Care

Publications: Organized Home Care at Montefiore Hospital and Medical Center

Procedure Manual for Home Care

Guide to Organized Home Care

Selected Case Histories

Bibliography on Organized Home Care

List of Selected Reprints

Audio-visual aids: "Home Care: An Approach to the Treatment of Chronic Disease," sound film

Available from: Health and Welfare Materials Center
10 E. 44 Street
New York, New York 10017

Address: Director, Training Programs in Home Care
Montefiore Hospital and Medical Center
111 East 210th Street
Bronx, New York 10467

Montefiore Hospital, Pittsburgh

Training and Information Center for Home Care and Related Community Services for Chronically Ill

Publications: Home Care Services for the Terminal Patient and His Family, case book

A Case Book of a Coordinated Home Care Program for Children

Case Book of a Coordinated Home Care Program

Selected Papers from Institutes:

Coordinated Home Care for Hospitals

The Physician and Hospital Home Care

The Patient Comes First

Audio-visual aids: "The Hospital Patient at Home," revised, 1966, sound film strip

"The Hospital Patient at Home," excerpt of above film strip

"The Forgotten Patient," sound film

"Coordinated Home Care," portable table display exhibit

Address: Educational Director, Training and Information Center for Home Care and Related Community Services for the Chronically Ill

Montefiore Hospital Association of Western Pennsylvania
3459 Fifth Avenue
Pittsburgh, Pennsylvania 15213

Rancho Los Amigos Hospital
Home Care Training Program
Address: Director, Home Care Training Program
Rancho Los Amigos Hospital
7601 East Imperial Highway
Downey, California 90242

The University of Michigan, School of Public Health
Home Care Training Center
Publications: List of Selected Reprints
Address: Coordinator, Home Care Training Center
School of Public Health
The University of Michigan
Ann Arbor, Michigan 48104

University of North Carolina, School of Public Health
Adult Health Services Regional Training Center
Address: Director, Adult Health Services Regional Training Center
School of Public Health
University of North Carolina
Chapel Hill, North Carolina 27515

Other Resources

State health departments

State welfare departments

Public Health Service, regional offices

National League for Nursing, state leagues

American Hospital Association, state associations

Extension services or adult education programs of community colleges or universities[1]

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[1] This is the only resource listed which is specific for the educational aspects of training. All of the other resources, including the training centers, may provide consultation in relation to agency program development as well as training.

APPENDIX C

FIELD TRIPS

As a part of the training course field trips to selected coordinated home care programs may be desirable and possible. These field trips may serve to illustrate concepts and functional areas covered in the training sessions. It may be helpful to ask on application to the course what field observations might be of interest to the trainee.

The program(s) to be used should be selected on the basis of what the program can demonstrate. It is recommended that the person involved in conducting the training course visit the selected program or programs beforehand.

The trainer and the home care program administrator should plan the objectives of the trip, time of the proposed trip, the responsibilities of the trainer, trainees, and program staff, and any financial arrangements for the trip.

The trainees should be oriented to the particular program they visit, and the program staff should have information regarding who the trainees will be and the objectives of their visit. The program visited should not be presented as a prototype for all programs. The needs and interests of the trainee should be considered when planning observations so that the trainee can relate his observations and the course content to his community setting.

In planning the trip evaluation methods should be developed from the standpoint of the trainer, trainee, and program staff.

APPENDIX D

EVALUATING THE TRAINING COURSE

Evaluation is the process of determining whether the trainee has learned at the end of the training period (or at another specified time), what the trainer feels is important or essential for him to have learned. The course may be designed to teach:

1. Facts
2. Skills
3. Attitudes, i.e., predispositions to act in certain ways
4. Behaviors

Many training courses are evaluated on the basis of reactions to the course. The evaluator asks how the trainees liked it, what they thought they got from it, and how they think they will use what they learned. This information may be helpful in improving administration of future courses, faculty presentations and participation, and methods of teaching. However, this type of evaluation does not help very much in assessing the extent of learning or change.

The evaluation process is based on the principle of evaluation stated in Unit X: relating input (training activities) to output (certain knowledge, skills, attitudes, and behaviors). This process requires the following steps:

1. Determine the objectives of the course, spelled out in detail and attainable
2. Pretest all trainees, preferably just before the course starts, to determine the level of their knowledge, skill, or attitudes before the course
3. Test the trainees at the end of the course
4. Compare what they did before the course with what they did after and with what you expected them to be able to do or learn

If the trainees do not fully achieve the objectives for the course, try to analyze why by answering these questions:

1. Were the objectives impossibly difficult to achieve or were they the wrong objectives?
2. Did the faculty fail to provide them with the necessary learning experiences?
3. Was there poor planning in not allowing sufficient time or in not using the most efficient methods to achieve the objectives?
4. Was the ability or knowledge level of the trainees too low originally?

This kind of analysis will be of great value for planning future courses. Setting reasonable objectives (desired outcomes) for the training course is one of the most important aspects of planning.